Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date May 10, 2022
Inspection Number 2022_1281_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royale Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Trillium Retirement and Care Community

Lead Inspector
Wendy Brown (602)

Inspector Digital Signature
Wendy K Brown
2022.05.11 11:39:57 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 26-29 and May 2-3, 2022

The following intake(s) were inspected:
Log #006743-22 (Complaint) related to improper care and medication administration concern(s).
Log #002479-22 (Critical Incident #2790-000007-22) related to alleged staff to resident physical abuse.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, s. 6. (7).
The licensee failed to ensure that the care set out in a resident's toileting plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A Personal Support Worker assisted a resident to the toilet and left the bathroom indicating the resident should use the call bell when they were done. The resident's plan of care outlined that a staff member was to be present during toileting given the resident's risk for falls.

Sources:
Resident's plan of care, messaging to home area staff and an interview with an Assistant Director of Care.

WRITTEN NOTIFICATION MEDICATION ADMINISTRATION

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 131 (1).
The licensee failed to ensure that a resident was administered their prescribed medication.

Rationale and Summary
A resident was administered medication that had not been ordered by a physician. The error was discovered, the resident was assessed and monitored as per the physician's direction and suffered no ill effects. Incorrect medication administration could cause adverse effects/ resident harm.

Sources:
Resident progress notes and the electronic medication administration record, the medication incident notification report and interviews with resident family, an Assistant Director of Care and other staff.