

Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch Ottawa Service Area Office 347 Preston Street, Suite 420 Ottawa ON K1S 3J4 Telephone: 1-877-779-5559 OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date	May 10, 2022		
Inspection Number	2022_1281_0001		
Inspection Type			
	tem 🗵 Complaint	□ Follow-Up	□ Director Order Follow-up
$\hfill\square$ 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			

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

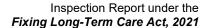
INSPECTION RESULTS

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.





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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.