Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2019	2019_685648_0022	017141-19, 017484-19, 019176-19	Critical Incident System

Licensee/Titulaire de permis

Trilogy LTC Inc.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOVAIRIA AWAN (648), JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 20, 22, 25, and 26, 2019.

The following Critical Incident System Reports were inspected:
Log #017141-19, related to a fall,
Log #017484-19, related to a fall,
Log #019176-19, related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurse (RPN), Business Manager (BM), and the Director of Care (DOC).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviewed of health records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect misuse or misappropriation of a resident's money, immediately reported the suspicion and the information upon which it was based to the director.

The licensee submitted a Critical Incident System (CIS) report, log #019176-19 to the Ministry of Long Term Care, related to resident #003 on an identified date. The CIS identified that the residents power of attorney (POA) for finances had failed to pay fees for resident #003 for an identified period of time. The home informed Public Guardian and Trustee, Elder Abuse, and police authorities to pursue further investigation into the matter at the time of submitting this CIS report to the MLTC.

Review of the CIS and the homes records including the BM's Administrative Communication Log related to resident #003's POA of finances identified multiple instances of communications between the POA and the homes BM over an identified period of time. During the review period, resident #003's POA was informed of the outstanding balance and advised on how to proceed to rectify resident #003's finances related to outstanding payment to the home.

Interview with the homes BM identified they had contacted resident #003's POA of finances on multiple instances, to which the POA failed to respond. The BM stated they were concerned regarding the POA's lack of follow up. The BM stated they anticipated the POA would respond to their communications, but suspected financial mismanagement prior to informing the MLTC of suspected financial abuse. The BM contacted the licensee's business consultant with their concerns following this period and was directed to report to the MLTC of suspected financial abuse. Review of the homes reporting policy and legislation with the BM identified they were aware of immediate reporting requirements but failed to report suspected financial abuse when it was identified and did not immediately report to the MLTC.

The above information was reviewed with the homes DOC. The DOC indicated the homes Administrator had submitted the CIS report following review of the information with the homes BM, and acknowledged suspected financial abuse identified was not immediately reported to the Director. [s. 24. (1)]

Issued on this 4th day of December, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.