Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Apr 29, 2022	2022_878551_0005	014197-21, 019300-21, 019631-21, 019703-21	Complaint

Licensee/Titulaire de permis

Trilogy LTC Inc.
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

MEGAN MACPHAIL (551), LISA CUMMINGS (756), MANON NIGHBOR (755)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 28, 29, 30 and 31 and April 1, 2022.

The following intakes were inspected as part of this Complaint inspection:
014197-21 was related to concerns about the care of residents.
019300-21 was related to concerns about pest control.
019631-21 was related to concerns about the care of a resident.

019703-21 / Critical Incident System 2899-000015-21 was inspected.

During the course of the inspection, the inspector(s) spoke with Dietary Aides, Personal Support Workers (PSWs), a COVID-19 Surveillance Tester, Registered Nursing Staff, the Behavioural Supports Ontario Nurse, the Infection Prevention and Control (IPAC) Nurse, the Social Worker, the Food Services Manager, the Environmental Manager, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed relevant documents including health care and pest control records and observed staff and resident interactions and IPAC measures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that safe positioning techniques were used when assisting a resident.

A resident, who was at risk for falls, required specific falls and injury prevention strategies.

At the start of their shift, the PSW who was assigned to care for the resident, performed a visual check, and the resident was in bed, as per their routine. Before the PSW was able to provide assistance to the resident, the resident fell .

The DOC stated that the PSW failed to ensure that the resident was safely positioned in their bed as they did not ensure that the required falls and injury prevention strategies were in place.

The resident sustained an injury.

Sources: A resident's health care record and interviews with staff. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 5th day of May, 2022

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

Original report signed by the inspector.