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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 29, 2022
Inspection Number 2022_1383_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Trilogy LTC Inc.

Long-Term Care Home and City
Chartwell Trilogy Long Term Care Residence, Scarborough

Lead Inspector
Catherine Ochnik (704957)

Inspector Digital Signature

Inspector Edith Sam (#741787) was present during this inspection.

Catherine Ochnik
Digitally signed by Catherine Ochnik
Date: 2022.07.11 09:56:04 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 6, 7, 8, 9 and 10, 2022

The following intake(s) were inspected:

- Intake # 001562-22 (Complaint) related to plan of care, falls prevention, availability of supplies, housekeeping, infection prevention and control (IPAC).
- Intake # 001297-22 (Complaint) related to IPAC, activities, short staffing, plan of care.
- Intake # 005964-22 Follow-up on a high priority CO #001 for inspection 2022_947752_0004 regarding IPAC practices with a compliance due date of May 27, 2022. The CO is related to s. 229 (4) of O. Reg. 79/10.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2022_947752_0004	001	704957

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Recreational and Social Activities
- Resident Care and Support Services
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

FLTCA s. 6 (7). The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. FLTCA s. 6 (7).

On a specified day, a resident was assisted by a staff member in the shower room. Progress notes indicated that the resident fell in the shower room, resulting in an injury. The resident was transferred to hospital. The resident's care plan indicated that they required two staff support with bathing.

In an interview, the staff member indicated that they were the only staff member assisting the resident in the shower room at the time of their fall. The staff acknowledged that the resident required two-person assistance with showering.

In an interview, the Acting Director of Care (ADOC) acknowledged that the resident's care plan indicated that the resident required two staff member assistance during showers. The ADOC also verified that only one staff member assisted the resident in the shower room on the day that they fell.

Impact or risk
As a result of only one staff assisting the resident during a shower, there was actual harm to the resident, as they sustained an injury and were transferred to hospital.

Sources:
Interviews with the resident and with staff.
The resident's clinical record, including resident care plan, post falls assessments, and progress notes.