Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: August 22, 2023	
Inspection Number: 2023-1383-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Trilogy LTC Inc.	
Long Term Care Home and City: Chartwell Trilogy Long Term Care Residence, Scarborough	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.08.31 16:31:59 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 10, 11, 2023.

The following intake(s) were inspected:

- Intake: #00089978, CI #2899-000024-23, related to falls;
- Intake: #00091559 - Complaint related to transferring and positioning techniques.

  - The following intakes were completed in this inspection: Intake: #00090745, CI #2899-000026-23, Intake #00091427, CI #2899-000030-23 and Intake #00091613, CI #2899-000029-23 were related to falls.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that a resident's Personal Health Information (PHI) was kept confidential.

Summary and Rationale
During an onsite inspection in the home, the inspector observed a medication cart on a unit, with the computer screen on the medication cart left open, revealing the Medication Administration Records of a resident.

There was no staff protecting the resident's PHI as they were in the dining room attending to the meal activities. After approximately two minutes, a Registered Practical Nurse (RPN) approached the medication cart. They confirmed that they were the nurse in charge of administering medications.

The RPN acknowledged that they were distracted when they left the computer screen unlocked while attending to other matters on the unit.
The Social Worker (SW) told the inspector that staff were expected to lock their medication carts and turn off their computer screens before walking away from it to protect the PHI of residents.

Failure to protect the resident's PHI on the electronic Medication Record (e-MAR) put them at risk of having their PHI jeopardized.

Sources: Observations of the medication cart, Privacy and Confidentiality policy #ALL-CA-ALL-600-02-02, resident #005's electronic health records, interview with RPN #104 and others.
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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Summary and Rationale

A complaint was made to the Director, regarding a resident for concerns related to allegations of improper care that resulted in potential harm to the resident.

The resident's care plan indicated that they required a type of assistance for their transfers.

The home's investigation notes indicated that on an identified date that an injury was identified on the resident, a Personal Support Worker (PSW) performed a transfer that did not align with the resident's transfer status. The notes indicated that the resident was sent to a trauma centre for further investigations.

The PSW told the inspector that they were uncertain they followed the resident's proper transfer status, as indicated in their care plan.

The Social Worker (SW) told the inspector that their investigations led the home to believe that the PSW did not follow the policy when they performed a transfer on the resident that day.

Failure to use safe transferring and positioning devices or techniques when assisting residents put them at risk for injuries.

Sources: resident #003's electronic health records, the home's investigation notes, interview with SW #105 and others.
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