Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2014	2014_348143_0026	O-000735-14	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE EAST INC.
400 Applewood Crescent Suite110 VAUGHAN ON L4K 0C3

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

TRILLIUM CENTRE
800 EDGAR STREET KINGSTON ON K7M 8S4

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

PAUL MILLER (143)

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 27th and 28th, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and two Associate Directors of Resident Care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Safe and Secure Home

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	Legendé 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care assess safety risk.

Resident #1 with exit seeking behaviors eloped from the Nursing Home on three occasions. On a specified date Resident #1 exited from the Nursing Home and was immediately redirected by the staff to return to the home. On a specified date Resident #1 exited from the Nursing Home and another resident advised staff that Resident #1 was on the sidewalk walking along Taylor Kidd Boulevard. Staff intervened and the resident was escorted back to the home. On a specified date the Associate Director of Resident Care (ADOC) spoke with a family member and had discussed moving the resident to a secure unit within the home. The ADOC documented that the family member would advise her of the decision to move Resident #1 to a secure unit.
On a specified date Resident #1 eloped from the Nursing Home. It was reported that the resident was observed in the middle of Taylor Kidd Boulevard and that a driver passing by stopped and persuaded the resident to come off the road. This person called the local police department and the resident was returned to the home by police. The resident sustained no injuries.

A review of the residents plan of care indicated that the residents risk for elopement had not been identified as a risk until after the second elopement. The home completed a care conference with the family and one to one staffing was put in place following the third elopement. The resident was relocated to a secure unit with the Nursing Home. [s. 26. (3) 19.]

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 all residents be assessed for elopement risk and that the plan of care be updated as required, to be implemented voluntarily.

Issued on this 28th day of November, 2014

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

Original report signed by the inspector.