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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2014	2014_348143_0010	O-001067-13 O-001231-13	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): July 21-22, 2014.

Critical Incident Log #O-000009-14 was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, an Associate Director of Care, a Registered Practical Nurse, the Office Manager, the Educational Coordinator and residents.

During the course of the inspection, the inspector(s) observed resident care and services, reviewed abuse policies and procedures, reviewed staff training programs, reviewed resident health care records inclusive of plans of care, assessments, progress notes and physician orders and medication records.

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

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The Licensee has failed to comply with the Long Term Care Homes Act section 76. (4) by not ensuring that staff receive annual training in all the requirements for Mandatory Reporting under section 24.

Ontario Regulation 79/10 section 219. (1) Retraining states the following:
The intervals for the purposes of subsection 76(4) of the Act are annual intervals.

A review of the homes current annual training indicated that the home has established an on line learning program called Upstairs training. A review of this training indicated that abuse must be reported immediately. This on line learning did not provide any explanations about Ontario Long Term Care Homes Act section 24 which identified that in addition to abuse training the home is required under section 24 to make mandatory reports in respect of improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident, unlawful conduct that resulted in harm or risk of harm to a resident and misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act of 2006. Interviews conducted with S101 and S108 confirmed that they had not received annual training in all the requirements under Section 24. [s. 76. (4)]

Issued on this 23rd day of July, 2014

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