

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de
longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 8, 2019	2019_505103_0026	012989-19, 013581- 19, 014536-19, 015445-19, 016586- 19, 016794-19, 017194-19	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale
Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 Edgar Street KINGSTON ON K7M 8S4

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

DARLENE MURPHY (103)

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): September 24-27, 30, October 1-4, 2019.

The following logs were inspected:

Log #012989-19 (CIS #2790-000026-19), Log #014536-19 (CIS #2790-000028-19), Log #015445-19 (CIS #2790-000029-19), Log #016794-19 (CIS #2790-000032-19), and Log #017194-19 (CIS #2790-000033-19)-resident falls that resulted in an injury, Log #013581-19 (CIS #2790-000027-19)-medication incident, Log #016586-19 (CIS #2790-000031-19)-alleged incident of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), a Registered Nurse (RN), the Physiotherapist (PT), Behavioural Support Lead, Assistant Director of Care (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspector reviewed the critical incidents and resident health care records including progress notes and resident plans of care and made resident observations.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure no drug was used by or administered to resident #006 unless it was prescribed for that resident.

The home submitted a critical incident (#2790-000027-19) to report resident #006 was given, in error, medications not prescribed for them by RPN #107. DOC #110 was interviewed and the medication incident as well as the home's response to the incident was reviewed.

The resident was monitored and fully recovered without transfer to the hospital. [s. 131. (1)]

Issued on this 8th day of October, 2019

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

Original report signed by the inspector.