Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
October 26 & 27, 2010	2010_124_2790_26Oct092116 & 2010_143_2790_26Oct110243	Follow-up-O-002343

Licensee/Titulaire
Specialty Care East Inc., 400 Applewood Crescent, Suite 110, Vaughan, ON L4K 0C3 Fax# 905-695-2940

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

Trillium Centre, 800 Edgar Street, Kingston, Ontario K7M 8S4 Fax# 613-547-3734

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Hamilton (124) and Paul Miller (143)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up to the inspection of two critical incidents. The first critical incident involved a witnessed abuse of Resident A by Resident B. The second critical incident involved an incident between Resident B and Resident C.

During the course of the inspection, the inspectors spoke with the administrator, the director of clinical services, and the operations manager of environmental services, six registered practical nurses, one programming staff member, the Medical Advisor and two residents.

During the course of the inspection, the inspectors completed a walking tour of the home, reviewed two resident health records, the home's abuse policy and procedure and a memo sent to staff.

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

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

WN # 1: The Licensee has failed to comply with LTCHA, 2007, S.O., c.8, s.30(2)
The use of a physical device from which a resident is both physically and cognitively able to release themself is not a restraining of the resident.

Findings:

1. A resident was observed wearing a seatbelt.
2. The resident could not identify the seatbelt as a restraint or articulate why he/she was wearing a seatbelt.
3. A review of the resident's clinical record indicated that the resident's seatbelt restraint was discontinued because the resident could undo the seatbelt himself/herself.
4. The resident does not meet the requirement of being able to cognitively release himself/herself from the seatbelt.

Inspector ID #:	#124 & #143