

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report	
Report Issue Date: August 22, 2023	
Inspection Number: 2023-1383-0004	
Inspection Type: Complaint	
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
Additional Inspector(s)	

INSPECTION SUMMARY
<p>The inspection occurred onsite on the following date(s): July 28, 31, 2023 and August 1, 2, 3, 4, 8, 9, 10, 11, 2023</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake: #00091762 - Complainant concerns with neglect, laundry services, housekeeping, and responsive behaviors.

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

- Resident Care and Support Services
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-maker (SDM), and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident was admitted to the home when they began refusing a type of care from the staff. This concern was brought to the attention of the home by the resident's Substitute Decision Maker (SDM) on several different occasions, and an intervention was suggested by the SDM. The resident's plan of care indicated that the family made several requests related to the resident's preferences.

The resident's electronic records indicated that the resident primarily refused the type of care over an identified period.

The ADOC told the inspector that they met with the family and discussed an intervention to assist in the resident accepting the type of care. The ADOC told the inspector that resident's care plan was not updated to reflect the suggested interventions from the family.

Failure to update the care plan based on the SDM's participation in the resident's plan of care placed them at risk for neglect.

Sources: Resident #001's electronic health records and interview with the DOC.
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WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)

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The licensee failed to ensure that cleaning was being done for four resident washrooms, as part of the organized program of housekeeping under clause 19 (1) (a) of the Act.

Summary and Rationale

On several units in the home, toilets in four resident washrooms, were unkept. The washroom floor in the first identified room was sticky with visible dust mites in the corners of the room. There were brown stains on the toilet seat, exterior of the toilet bowl, various brown stains on the floor, and urine odor. A broken toilet seat was observed in a second washroom and the seat was completely removed from the toilet and placed on the floor behind the toilet bowl. A third room, the toilet had dried fecal matter on the toilet seat, underneath the toilet seat and inside rim of the toilet bowl. It was brown in color with an unpleasant odour. A fourth washroom had fecal stains on toilet seat and lid and exterior rim of the toilet bowl.

The Environmental Services Policy #ALL-CA-ALL-500-03-03, titled, "Housekeeping Protocols" revised January 2015, indicated to maintain the living and working environments within each residence as esthetically pleasing, free of dirt, debris and odour; hygienic with the use of sanitation practices in the prevention of contamination /infection control.

Housekeeper #112 told the inspector that they were aware of the broken toilet seat the day before and did not complete a work requisition to have it fixed.

Housekeeper #103 told the housekeeper that residents with responsive behaviours sometimes refused to have their washrooms cleaned and that several attempts were made to clean the third washroom.

The Environmental Service Manager (ESM) told the inspector that the first and second washrooms were visibly unkept and that staff were expected to adhere to daily cleaning of resident's living areas. They confirmed that housekeeping staff were available seven days per week and were aware of the cleaning procedures and schedules of the units and the home.

Failure to maintain clean washrooms for residents in four residents' washrooms put their health at risk.

Sources: Maintenance work log, housekeeping procedures, resident #001's electronic health records, observations of four washrooms, Environmental Services policy #ALL-CA-ALL-500-03-03, interview with ESM and others.

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