

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 prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 31, Aug 9, 2012	2012_046166_0039	Critical Incident
Licensee/Titulaire de permis		
TRILOGY LTC INC. 100 Milverton Drive, Suite 700, MISSI Long-Term Care Home/Foyer de so		
TRILOGY LONG TERM CARE 340 McCowan Road, SCARBOROUG	H, ON, M1J-3P4	
Name of Inspector(s)/Nom de l'insp	ecteur ou des inspecteurs	
CAROLINE TOMPKINS (166)		
Ir	spection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse and a member of the Personal Support staff.

During the course of the inspection, the inspector(s) observed the resident and reviewed clinical health records.

The following Inspection Protocols were used during this inspection: Critical Incident Response

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
Legend	Legendé Legende Legendé Legendé Legendé Legende Legende Legende Legende Legend	
WN – Written Notification	WN - Avis écrit	
VPC - Voluntary Plan of Correction	VPC – Plan de redressement volontaire	
DR - Director Referral	DR – Aiguillage au directeur	
CO - Compliance Order	CO – Ordre de conformité	
WAO – Work and Activity Order	WAO – Ordres : travaux et activités	



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the 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 fovers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la LTCHA includes the requirements contained in the items listed in 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. 107. Reports re critical incidents Specifically failed to comply with the following subsections:

- s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection
- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
- 3. A missing or unaccounted for controlled substance.
- 4. An injury in respect of which a person is taken to hospital.
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants:

1. The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents. (Log 000699-12) Resident 01, sustained an injury during a transfer. The resident was transferred to the hospital for further investigation. The MOHLTC was not notified of the transfer to hospital due an injury within the legislated time

(Log 002564-11) Resident 02 was found on the floor ,an unwitnessed fall. The resident was transferred to the hospital for further assessment. The MOHLTC was not notified of the transfer to hospital due to an injury within the legislated time frame, [r.107.(3)4.]

Issued on this 9th day of August, 2012

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