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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
October 14, 15,18 & 19, 2010	2010_124_2790_14Oct130919	Complaint-log O-001889

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)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the care delivered to an identified resident.

During the course of the inspection, the inspector spoke with the administrator, the director of clinical services, the nurse practitioner, a registered practical nurse, three personal support workers and the resident's daughter.

During the course of the inspection, the inspector reviewed the resident's health record, reviewed policies in the home's pharmacy manual and conducted walking tour of the resident's home area.

The following Inspection Protocols were used during this inspection:
Pain Inspection Protocol
Continence Care and Bowel Management Inspection Protocol
Responsive Behaviours Inspection Protocol

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

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary

Findings:

1. A registered practical nurse reported that the resident's change in condition was slow.
2. The resident's Power of Attorney for Personal Care expressed concern about the resident's change in condition and the resident was assessed by the registered nurse.
3. There was an assessment by the physiotherapist. There was no change in the resident's plan of care in response to his/her change in condition until the resident presented with other symptoms.

Inspector ID #: 124

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to the resident being reassessed and his/her plan of care being revised when his/her care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.53 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

Findings:

1. The resident was up during the night and no behavioural triggers related to his/her night time behaviour had been identified.

Inspector ID #: 124

Additional Required Actions: [
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby

requested to prepare a written plan of correction for achieving compliance related to identification of the triggers related to the resident's night time behaviour, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. L Hamilton
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Nov. 26, 2010