Ontario

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 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 19, 2018	2017_552531_0034	023334-17	Critical Incident System

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

SUSAN DONNAN (531)

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): November 29, 30 and December 1, 2017.

Log # 023334-17 alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Nursing (ADON), the Clinical Care Coordinator (CCC), a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Life Enrichment staff (LE), a Restorative Care staff (RC), the Housekeeping staff (Hskp) and residents.
During the course of the inspection the inspector conducted a tour of the home, observed resident care and services, reviewed resident health care records, and the licensee's abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy that promotes zero

tolerance of abuse and neglect of residents was complied with.

Under O. Reg.79/10 s. 2 (1) physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Review of the "Abuse and Neglect Policy: Policy #G-1
Procedure:
If a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member or co-worker, the following steps must be taken:
1. Safeguard the resident immediately
2. Notify the nurse in charge

PSW #100 and #101 during separate interviews with inspector #531, indicated that on two occasions on a specified week during the lunch meal they observed RPN #111 rocking and shaking residents that had fallen asleep. PSW #100 indicated that she observed RPN #111 shaking resident #001's shoulder causing the resident to grimace in discomfort. PSW #100 indicated that she removed resident #001 from the dining room. PSW #101 indicated that she observed RPN #111, shaking resident #002 by the shoulder while asleep to administer the resident's medication. She indicated that the resident did not wake up however RPN #111 continued to attempt to place medication into the resident's mouth. She indicated she removed resident #002 from the dining area.

RPN #111 was not available for an interview as she is no longer employed by the home.

Both PSWs indicated that they did not immediately report the incident as per policy, for fear of retaliation by RPN #111. They indicated that this was the first that they observed RPN #111 being rough with a resident.

PSW #103 indicated that on a specified date she observed RPN # 111, who was administering medication to resident #003, rocking and shaking the resident's shoulder roughly, causing the resident to slam a fist onto the table. The RPN stopped the attempts to administer the medication. PSW #103 indicated that after discussion with PSW #100 and #101, they reported the incidents to Hskp Aide #107 who immediately reported the incidents to management.

During a subsequent interview, the DOC acknowledged that the licensee's written policy to promote zero tolerance of abuse and neglect of residents was not complied with as

PSW #100 and #101 did not immediately report the incidents they observed. The DOC advised that all staff involved have been re-educated in the abuse policy and immediate reporting. [s. 20. (1)] [s. 20. (1)]

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 to ensure the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of the abuse or neglect investigation were reported to the Director.

On a specified date, Critical Incident System (CIS) report was submitted to the Director related to alleged staff to resident abuse.

The Director of Care was interviewed and indicated the ADON or the Clinical Care Coordinator would be the person(s) responsible for submitting the alleged staff to resident abuse. She further indicated that she was responsible for the investigation of the alleged staff to resident abuse on the specified date, however she requested that the ADON/CCC submit the CIS report to the Director.

During an interview with ADON #108 and the CCC #106 they indicated that they were not involved in the investigation on the specified date therefore only completed the CIS report with the information provided them from the DOC. No additional amendments to this critical incident were made.

During a subsequent interview with the DOC and review of the CIS report she acknowledged that the results of the licensee's abuse investigation were not reported to the Director. [s. 23. (2)]

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 to ensure that the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately notified of the alleged physical abuse of resident #001, #002 and #003.

On September 28, 2017 a Critical Incident System (CIS) report was submitted to the Director related to alleged staff to resident abuse.

During an interview with Hskp Aide #107 on a particular date, she indicated that on a specified date PSW #100, #101 and #103 alleged RPN #111, being rough, rocking and shaking resident #001, #002 and #003 by the residents shoulder in an effort to waken the residents to administer a food or medications. She indicated that she immediately reported the incidents to the Director of Care.

The Director of Care was interviewed and indicated that on the specified date she immediately initiated an investigation, notified the residents SDMs, notified the appropriate authorities, assessed the residents however the Director was not notified until the submission of the CIS report. [s. 24. (1)]

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 to ensure that the Director is immediately notified of alleged abuse, to be implemented voluntarily.

Issued on this 19th day of January, 2018

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

Original report signed by the inspector.