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
Feb 26, 2018	2018_717531_0003	027308-17, 029635-17, 029707-17, 000972-18	Critical Incident System

Licensee/Titulaire de permis

Trent Valley Lodge Limited
195 Bay Street TRENTON ON K8V 1H9

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

Trent Valley Lodge
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): January 25 and 29, 2018.

Enter any additional information..

During the course of the inspection, the inspector(s) spoke with residents, residents Substitute Decision Maker (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Restorative Care Aide (RCA), Physiotherapy Aide (PTA), the Physiotherapist (PT), the RAI Coordinator, the Clinical Care Coordinator (CCC), the Assistant Director of Nursing (ADON) and the Administrator.
During the course of the inspection the inspector toured the home, reviewed resident health care records, observed resident care and services, reviewed the falls prevention program including policy and procedures and reviewed investigative notes and the abuse policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 verbal abuse of resident #003.

Under O. Reg.79/10 s. 2(1), verbal abuse is identified as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self- worth, that is made by anyone other than a resident.

On a specified date, Critical Incident System report was submitted to the Ministry of Health and Long Term Care.
The incident was described as alleged staff to resident verbal abuse.

On January 29, 2018 PSW #116 during an interview with inspector #531, indicated that on a specified date PSW #116 and PSW #117 were providing care to resident #003. PSW #116 indicated she witnessed PSW #117 respond to the resident with derogatory and demeaning comments. PSW #116 indicated that they removed the resident from the room, settled the resident and reported the incident to RPN #113. PSW #116 indicated that both the PSW and RPN #113 monitored the resident, who had no recall of the incident and no ill effects. The PSW indicated that written statements were requested the same day for the investigation.

RPN #113 was not available for an interview.
PSW #117 was not available for an interview.

During an interview with RPN # 103 (CCC), she indicated that when it was reported an investigation had been initiated, resident # 003 had been assessed and monitored, there were no ill effects to the resident and PSW #117 had left the building. The CCC indicated that she forgot to immediately report the incident to the Director. The CCC indicated she had no recall of the omission until approached by the DOC.

The Director of Care was not available for an interview as she is no longer employed by the home.

During an interview with the Administrator and review of the CIS report, investigative notes and analysis conducted by the DOC, the Administrator acknowledged that the Director was not notified until 10 days later. [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 a person who has grounds to suspect that any abuse has occurred or may occur shall immediately report the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 27th day of February, 2018

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

Original report signed by the inspector.