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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_603194_0010	027239-18, 004605-19	Complaint

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 8, 9, 10, 11 and 12, 2019

Inspector completed the following logs: Log #004605-19 and Log #027239-18 related to provision of resident care complaints

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurse (RN) and Registered Practical Nurse (RPN)

Reviewed the home's internal investigation into the complaints and clinical health records of identified resident.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of resident #002 and the resident's needs and preferences.

Log #004605-19

A written complaint was received from Substitute Decision Maker (SDM) of resident #002,. The SDM indicated that treatment for resident #002 had been delayed when results from a specified treatment were not reviewed.

During investigation of the complaint for SDM of resident #002, Inspector #194 reviewed the clinical health records, interviewed registered staff and the home internal investigation into the allegations.

The clinical health records for resident #002 indicated that on an identified date, the family requested a specified treatment be provided for resident #002. On the same day, an order for the specified treatment was obtained by physician.

During interview with RN #109 it was noted that the family had called a number of days later, to ask about results of the specified treatment. RN #109 indicated that the results were located at the front desk and had not been reviewed by the nursing staff. RN #109 indicated that on the same day, the physician was notified of the results from the specified treatment and a medication was ordered for the resident.

The licensee failed to ensure that the plan of care for resident #002 based on the results from a specified treatment was provided, according to the resident's needs and treatment was delayed four days. [s. 6. (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 by ensuring that the care set out in the plan of care is based on an assessment of the residents needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint received by SDM of resident #002 related to the care of the resident was immediately forwarded to the Director.

Related to Log #004605-19:

During inspection of a complaint, by the SDM of resident #002 on an identified date, Inspector #194 reviewed the clinical health records of the resident and the homes internal investigation.

During telephone interview with Inspector #194, SDM indicated specific care concerns related to resident #002 which had been provided in writing to the home.

The DOC indicated during interview with Inspector #194, that a complaint letter had been received by the SDM of resident #002 related to care concerns. The DOC provided Inspector #194 with the completed investigation related to the complaint, but expressed that they were unable to locate any information to verify that the MOHLTC had been informed of the complaint.

The licensee failed to immediately forward a written complaint received by SDM of resident #002, related to the care of a resident to the MOHLTC. [s. 22. (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 by ensuring that when a written complaint concerning the care of a resident is received, it is immediately forwarded to the Director, to be implemented voluntarily.

Issued on this 14th day of May, 2019

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

Original report signed by the inspector.