Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 14, 2019	2019_603194_0021	018698-19, 018950-19	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

CHANTAL LAFRENIERE (194)

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): October 1, 2, 3, 4, 7, 8, 10, 15, 16, 17, 18 and 21, 2019

The following logs were inspected during the inspection:
Log # 018698-19, related to a fall.
Log # 018950-19, related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Clinical Care Co-ordinator (CCC), Nurse Manager, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses, (RPN), and Personal Support Workers (PSW).

Observed the provision of staff to resident care and resident to resident interaction on the units. Reviewed clinical health records of identified residents, policies related to abuse and falls, Behavioural Ontario Support Documentation, staff orientation and training education material and home's internal investigation documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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 failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred, that resulted in harm or risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

A Critical Incident Report (CIR), was submitted to the Director, reporting an incident of abuse involving resident #005 and #006.

Review of the CIR, licensee's internal investigation notes and clinical health records for the identified residents were completed by Inspector #194. The CIR and internal investigation indicated that on an identified date, PSW #204 witnessed resident# 005 being abusive towards resident #006. RN #211 indicated that they were called to assess the situation. RN #211 indicated to Inspector #194 that both residents were separated and assessed with no injuries. Manager on-call and Clinical Care Co-ordinator (CCC) #103, were notified.

During an interview with Inspector #194, the CCC #103 indicated that they were the manager on-call at the time of the abuse incident. RN # 211 was nurse in charge, and called to inform CCC #103 of the incident. The CCC #103 indicated that after discussion with RN #211 it was decided that incident was not required to be immediately reported to the Director. The CCC #103 stated that this incident was the first time they were on-call manager at the home and RN #211 was also a new hire at the home. The CCC#103 indicated that when the incident was further discussed with the DOC the following day is was decided that the Director would be notified.

The licensee failed to ensure that the Director was immediately notified of an abuse incident where there was a harm or risk of harm to resident# 006 on an identified date. [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 by ensuring that a person who has reasonable grounds to suspect that abuse of a resident has occurred, immediately reports the information to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff at the home have received training as required related to the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

A CIR was submitted to the Director, reporting an incident of abuse involving resident #005 and #006.

Review of the CIR, licensee's internal investigation notes and clinical health records for the identified residents were completed by Inspector #194. The CIR and internal investigation indicated that, PSW #204 witnessed resident# 005 being abusive towards resident #006. RN #211 indicated that they were called to assess the situation. RN #211 indicated to Inspector #194 that both residents were separated and assessed with no injuries. Manager on-call and CCC #103 were notified.

During an interview with Inspector #194, related to abuse education provided to staff involved in the abuse incident reported in the CIR, DOC indicated that abuse education had last been provided to staff at the home on an identified date, explaining that the home had not completed the annual abuse education for 2019. DOC indicated that the abuse education had been scheduled earlier on in the year but had to be cancelled and had not been rescheduled at this time.

During an interview with Inspector #194, Administrator indicated that the abuse education had been scheduled for an identified date, but had to be cancelled. Administrator has indicated that the abuse education has not been rescheduled and it is her hope that it would be provided by November 2019. Administrator has indicated to Inspector #194 that the home is looking into alternative ways of providing the education related to the budgetary constraints for the home at this time. Administrator indicated to Inspector #194 that she was not aware of how new hires were provided abuse education, stating that the DOC was responsible for the abuse education in the home. Administrator indicated that it was her understanding that all new hires were provided orientation and was unable to speak to specifics of the orientation education for new hires.

During an interview with Inspector #194, related to the orientation training and abuse education, RPN #220 (Nurse Manager) at the home indicated that they started in their role as Nurse Manager on an identified date. RPN # 220 indicated that on an identified date they were given the responsibility of taking over the orientation process for new PSW hires in the home, RPN #220 indicated there was no direction for orientation of the registered staff at the home. RPN #220 explained that they were not provided any education or training as to what was required related to the orientation process for new hires in the home. It was hoped that abuse education training for staff would be provided over a specified period but during this period, full-time PSW staff were on unavailable.

Staffing became an issue and there was no time for the orientation process to be provided. RPN #220 indicated that starting on an identified date, a specified number PSWs where provided orientation, which included the Mission, Vision statement were reviewed as well as a number of human resource concerns. RPN #220 indicated that PSW were provided verbally the required expectation of their role, if they witnessed abuse to notify the charge nurse, no copy of the policy was provided or reviewed. RPN #220 indicated that they were not aware of the requirements in the Long-Term Care Home Act or Regulation related to orientation and annual education for staff in the home.

During another interview with Inspector #194, related to abuse education and new hires, DOC indicated that there had been a specified number of PSW and registered nurses hired during an identified period. DOC indicated that of the newly hired staff, there were currently a specified number PSW's on Leave of Absences and of the newly hired registered staff a specific number were casual staff, that remained in the home at the time of the inspection. DOC confirmed for date worked for the following newly hired staff; RN #103, RN #210, PSW #204 and PSW #215. .

During an interview with Inspector #194, RN #210 indicated that they started their employment at the home as RPN. RN #210 indicated that upon hire they received orientation for RPN and RN positions from co-workers. RN #210 indicated that education related to Abuse and MOH notification was provided by co-workers during orientation. RN #210 indicated that they worked on an identified date and had not been back to the unit since.

During an interview with Inspector #194, PSW #204 indicated that during orientation they were not provided with any abuse education and no policies were reviewed. PSW #204 indicated that their orientation consisted of shadowing a PSW staff on the unit for a number of shifts, no other education was provided. PSW #204 indicated that they had not received any further abuse education since being hired.

During an interview with Inspector #194 related to abuse education provided, the CCC #103 indicated that there was no abuse education provided upon hire. The CCC #103 indicated to inspector #194 that they took it upon themself, when hired to review and become familiar with the abuse policies at the home.

During an interview with Inspector #194, PSW #215 indicated that they were provided two day, evening and night shifts during the orientation and did not feel that this was sufficient and spoke to RPN charge #220 related to this, but was not provided any

additional orientation shifts. PSW #215 indicated they were not provided any education or policy review related to abuse, restraints, whistle-blowing or fire drills during or since their orientation.

During an interview with Inspector #194 , RPN #216 indicated that they had provided orientation to new hires over the last few months. RPN #216 explained that the orientation provided to new registered staff consisted of the day to day operations of the home. RPN #216 indicated that there was no time to review policies related to abuse or restraints or 24 hour mandatory reporting requirements. RPN #216 indicated during interview that new registered staff are provided 2-3 orientation shifts.

During an interview with Inspector #194, PSW #218 indicated that they have provided orientation to new PSW's in the last few months. PSW #218 indicated that they would go over the day to day operations in the home and resident care needs. PSW #218 indicated that they review transfer and abuse policy with the new staff on orientation. PSW #218 indicated that direction is provided to new staff that if they witness abuse that it is to be reported to the charge nurse.

During an interview with Inspector #194, PSW #219 indicated that they had provided orientation to new PSWs in the last few months. PSW #219 indicated that they reviewed the day to day operations of the home and resident care, documentation for residents in charts and directed new PSW staff to notify the charge nurse if there was any abuse witnessed and also reviewed the practice in the home related to lifts and transfers. PSW# 219 indicated that they did not review any policies with new staff or discuss fire drill processes.

The licensee failed to ensure that RN #103, RN #210, PSW #204 and PSW #215 received training as required related to the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

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 staff receive training related to the home's abuse and neglect of residents policy prior to performing their responsibilities, to be implemented voluntarily.

WN #3: 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 failed to ensure that the "Abuse and Neglect of a resident -actual or suspected" policy was complied with on an identified date, when resident #005 was witnessed to be abusive towards resident #006.

A CIR was submitted to the Director, reporting an incident of abuse involving resident #005 and #006.

Review of the licensee's "Abuse and Neglect of a resident – actual or suspected" policy was completed by Inspector #194 and indicated;
Reportable matters include
- any incident with respect to alleged, suspected or witnessed abuse of a resident by anyone or alleged, suspected or witnessed neglect of a resident by the home or staff.
-unlawful conduct that resulted in harm or risk of harm to a resident.
-upon hire and annually thereafter, all staff and volunteers will receive in-service education on the topic of abuse and neglect, strategies to prevent abuse and neglect and the reporting of abuse and neglect.

PROCEEDURE:
the nurse will
-immediately notify DOC/Administrator.
NOTE: the Administrator/DOC will provide.
direction to the RN in charge regarding the notification of the police.

The Director of Care or designate will:
-Notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.
-Advise the MOHLTC Director regarding ongoing investigation through the MOHLTC Critical Incident System .

Review of the internal investigation into the incident of abuse involving resident #005 and #006 was completed by Inspector #194 and verified that the incident was not immediately reported to the Director and that the results of the abuse investigation were not reported to the Director.

The incident described in CIR occurred on an identified date and were not reported to the Director until, one day later.

The results of the abuse investigation were not reported to the Director at the time of the Inspection. Resident #005 was transferred to hospital on an identified date for assessment and returned to the home the following day, where resident was provided behavioural interventions. Resident #005 was transferred to hospital four days later and was awaiting further assessment.

During an interview with Inspector #194, DOC indicated that there had not been any abuse education/training provided to staff for 2019, stating that the mandatory education had been planned for earlier in the year and was cancelled and had not yet been rescheduled.

During an interview with Inspector #194 related to abuse education provided, the CCC #103 indicated there was no abuse education provided upon hire. The CCC #103 indicated to inspector #194 that they took it upon themselves when hired to review and become familiar with the abuse policies at the home.

During an interview with Inspector #194, RN #210 indicated that they started their employment at the home as RPN. RN #210 indicated that upon hire they received

orientation for RPN and RN positions from co-workers. RN #210 indicated that education related to abuse and MOH notification was provided by co-workers during orientation.

During an interview with Inspector #194, PSW #204 indicated that during their orientation they were not provided with any abuse education and no policies were reviewed. PSW #204 indicated that they had not received any further abuse education since hire.

The licensee failed to ensure that it's abuse policy was complied with, when an incident of abuse which occurred on an identified date was not immediately reported, the results of the abuse investigation was not reported to the Director and the training related to the home's abuse policy was not provided to staff on hire. [s. 20. (1)]

WN #4: 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 failed to report to the Director the results of the abuse investigation involving resident #005 and #006 on an identified date.

A CIR was submitted to the Director, reporting an incident of abuse involving resident #005 and #006.

During an interview with Inspector #194, the CCC indicated that they were waiting for Central Intake Integration Assessment Team (CIATT) to contact the home with a request for the outcome of the abuse investigation, then the information would be provided to the Director.

The results of the abuse investigation involving resident #005 and #006 reported in CIR were not reported to the Director. Resident #005 was transferred to hospital on an identified date for assessment and returned to the home to following day and provided with behavioural interventions. Resident #005 was transferred to hospital four days later and was awaiting further assessment. [s. 23. (2)]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.