Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 5, 2020	2020_603194_0009	023924-19, 001473-20	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), CAROLINE TOMPKINS (166)

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): March 2 and 3, 2020

The following intakes were completed in this critical incident system inspection: Log #023924-19 and Log #001473-20, for resident to resident abuse.

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

The Inspectors observed resident to resident interaction and staff to resident provision of care. The inspectors reviewed clinical health records of identified residents, internal abuse investigation notes and the licensee's abuse policy.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident Report was submitted to the Director reporting that resident #003 had been abusive towards staff. Resident #003 was removed from the dining area and given one to one support. When the PSW left the area to notify the registered staff of the situation, the PSW overheard resident #003 become confrontational with other residents. The PSW returned and observed resident #003 making threatening gestures, directed towards resident #004. Resident #004 was abusive towards resident #003. No injuries to either resident were noted.

An after hours call to the Action Line was received reporting an incident of resident to resident abuse.

During an interview with inspector, resident #004 indicated, resident #003 threatened resident #004 and they were abusive towards resident #003. Resident #004 indicated a couple days post incident resident #003 apologized for their actions and the two residents shook hands.

The Director of Care and Registered Nurse #109, confirmed that the police were not notified of the incident of resident to resident abuse that occurred.

The licensee failed ensured that the appropriate police force was notified of the witnessed incident of abuse which occurred, between resident #003 and resident #004. [s. 98.]

Issued on this 9th day of March, 2020

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

Original report signed by the inspector.