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
Sep 23, 2021	2021_885601_0014	019998-20, 020895-20, 022332-20, 023749-20, 001015-21, 001402-21	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

KARYN WOOD (601), SARAH GILLIS (623)

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): On-site June 14, 15, 16, 17, 18, 21, 22, 23, July 6, 7, 8, 9, 19, 20, 21, 22, 23, 26, and 27, 2021. Off-site June 24, 25, July 5, 12, 13, 14, 15, 16, 2021.

The following intakes were completed in this Critical Incident Report (CIR) Inspection:

Log #019998-20; Log #020895-20; Log #001015-21; and Log #001402-21 related to a fall that resulted in a significant change in condition.

Log #022332-20 related to missing narcotics.

Log #023749-20 related to allegations of staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator (CCC), Registered Practical Nurse/Nursing Manager (RPN/NM), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Laundry/Housekeeping/Nutrtional Supervisor, Housekeeping/Dietary Aide, Personal Support Workers (PSW), Resident Care Aide (RCA), Support Service Worker (SSW), Maintenance Manager (MM), Maintenance Worker (MW), Dietary Aide (DA), Life Enrichment Coordinator (LEC), Activity Aide (AA), Administrative Assistant (Admin A), and residents.

The inspectors also reviewed resident health care records, policies, education records, meeting minutes, licensee's internal investigation, observed the delivery of resident care and services, including staff to resident interactions and infection control practices in the home.

Please note: Within this inspection, findings of non-compliance under s. 24. (1) and s.19 (1) of the LTCHA was noted and will be issued within the Complaint Inspection #2021_885601_0015 report.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **8 WN(s)**
- **5 VPC(s)**
- **2 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. 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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with when staff failed to report allegations of abuse towards six residents by two PSWs.

The licensee's Abuse and Neglect of a Resident - Actual or Suspected policy indicated that all staff members have an obligation to report any incident or suspected incident of resident abuse. If a staff member or volunteer become aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker they must notify the nurse of actual or suspected abuse. The nurse will notify the registered nurse in charge of the home and immediately notify the Director of Care/Administrator, the Director of Care or designate will immediately notify the MOHLTC Director.

Review of the licensee's internal investigation for allegations of abuse towards six residents by two PSWs, revealed that multiple staff in the home were aware of the ongoing abuse towards the residents and did not report it. A staff interviewed indicated they had witnessed the abuse towards the resident about a month prior to the abuse investigation and they should have immediately reported what they had witnessed. They further indicated that the PSWs action towards the resident did not feel right and they were not clear if the PSWs actions would be considered abuse and reportable.

During an interview the DOC indicated that the home expectation is that all staff will follow the zero tolerance of abuse policy and will immediately report any alleged, suspected or witnessed abuse of a resident. The DOC confirmed that staff did not follow the policy.

When alleged, suspected, or witnessed abuse was not immediately reported by staff, the residents of the home were at actual risk of harm when the abuse continued for approximately three months before being reported.

Sources: Critical Incident Report, Abuse and Neglect of a Resident Policy, licensee's internal investigation, staff interviews. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 of the LTC Home Act.

Review of the licensee's annual education for 2020 was completed. The records indicated that 50.4% of the homes staff completed education on the home's policy to promote zero tolerance of abuse and neglect of residents, which has embedded in it, the duty to make mandatory reports under section 24. There was no record of any annual education related to the Residents' Bill of Rights.

During interviews multiple staff indicated they had never received training or had not received training for approximately three years related to the homes abuse policy and they could not recall ever being educated on the Residents' Bill of Rights, and the duty to make mandatory reports under section 24 of the LTC Home Act.

During separate interviews the Administrative Assistant (Admin A) #145 and the Manager of Life Enrichment (LEC) #132 indicated in December 2020 there was a staff meeting and there was a discussion about the abuse policy. According to the meeting minutes, 49 staff including managers attended the staff meeting. The Admin A and LEC indicated the abuse policy was distributed to staff to complete their education as a read and sign, then return the sign off sheet. The LEC and Clinical Care Coordinator (CCC) #102 indicated that this was the only education in 2020 since the beginning of the pandemic and there has been no education for staff so far in 2021.

During an interview the Director of Care (DOC) indicated that in December 2020 all staff were provided with a copy of the homes abuse policy and were to complete a sign off

sheet and return it, to indicate they had read and understood the policy. The DOC indicated that there was no follow-up to ensure that all staff returned the document and was unaware that 49.6% of the staff had not completed the read and sign education document. The DOC confirmed that the annual education did not include the Resident's Bill of Rights.

When staff were not educated annually related to The Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 of the LTC Home Act the residents were placed at actual risk of abuse and neglect as a result.

Sources: Education records, meeting minutes, staff interviews. [s. 76. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas, equipped with locks to restrict unsupervised access to those areas by residents, were locked when they were not being supervised by staff.

Observations in the home by Inspector #623 and Inspector #601 throughout the course of the inspection, there were multiple occasions when the clean utility rooms on all home areas were observed to have the door to the room propped open with the installed door stop and the rooms were not being supervised by staff. The clean utility rooms contained items for personal care as well as chemicals for cleaning. There was no call bell identified in these rooms. On multiple occasions there were residents observed in the hallway outside of the clean utility room and there were no staff present.

During separate interviews two PSWs indicated that the doors to the clean utility rooms were sometimes open and sometimes closed. They indicated that the doors do have a lock and require a code to open them. They both indicated that the clean utility room was not a resident area and that residents should not be in the room unsupervised.

The residents were at risk of injury when the clean utility room doors were observed to be propped open and left unsupervised on multiple occasions, the rooms contained cleaning chemicals that could be hazardous to the residents.

Source: observations in the home, interview with PSWs and CCC. [s. 9. (1) 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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

s. 21. (4) The licensee shall keep a record of the measurements documented under subsections (2) and (3) for at least one year. O. Reg. 79/10, s. 21 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

During the inspection it was identified that the home felt cool. A tour of the home on two separate dates to record the temperature in random resident rooms and the resident common areas on all floors, was conducted by the Inspector. Temperatures were recorded in multiple resident rooms and were all below 22 degrees Celsius. Temperatures were also recorded below 22 degrees Celsius in three resident lounges and one resident dining room. One resident was observed to have a device on the floor of their bedroom to raise the temperature, the resident was wearing multiple layers of clothing and had three blankets on.

During an interview the Maintenance Manager (MM) indicated that the thermostats in the home are not locked out and they can be adjusted. The MM indicated that ideally, they would be set at 22 degrees Celsius but they cannot control if people are adjusting them.

The air makeup in the hallways is controlled centrally and is set for 22 degrees Celsius, this temperature will change as cooler air flows from resident rooms that are at a lower temperature and lounges or dining rooms. The temperature is also affected when staff, residents or visitors open the windows. The MM indicated that most thermostats have the ability to be locked out so the temperature cannot be changed, but this has not been done. The MM indicated that on the second and third floors, the thermostats are located in one resident room and controls the temperature for up to four other rooms. Not every room has individual temperature control.

Residents were at risk of becoming too cold when the temperature in the home was not maintained at a minimum of 22 degrees Celsius.

Sources: Observations and temperature checks throughout the home, interview with MM. [s. 21.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing for at least two resident bedrooms in different parts of the home.

During an interview the MM indicated that they have not been taking and recording temperatures for resident bedrooms in different parts of the home. The MM indicated they were unaware that this was a requirement.

Residents were at risk for the home not being maintained above 22 degrees Celsius, when the temperatures were not measured and documented in resident bedrooms, in different parts of the home.

Sources: Interview with MM. [s. 21. (2) 1.]

3. The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor.

During an interview the MM indicated that they have not been measuring and documenting temperatures in one resident common area on every floor of the home. The MM indicated they were unaware that this was a requirement.

Residents were at risk for the home not being maintained above 22 degrees Celsius, when the temperatures were not measured and documented in one resident common areas on every floor of the home.

Sources: Interview with MM. [s. 21. (2) 2.]

4. The licensee failed to ensure that temperatures required to be measured under subsection (2) - at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, which may include a lounge, dining area, or corridor; documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

During an interview the MM indicated that no air temperatures have been measured and documented for the home. They were unaware of the requirement to complete this three times a day.

Residents were at risk for the home not being maintained above 22 degrees Celsius, when the temperatures were not measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Sources: Interview with MM. [s. 21. (3)]

5. The licensee failed to ensure that there was a record of temperature measurements for the home for at least the last year.

During an interview the MM indicated that there was no record of temperatures being taken for the home, this was never completed and documented. The MM indicated they were unaware this was a requirement.

Residents were at risk for the home not being maintained above 22 degrees Celsius when a record of temperatures was never obtained.

Sources: Interview with MM. [s. 21. (4)]

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 home is maintained at a minimum temperature of 22 degrees Celsius, that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor, The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, shall keep a record of the measurements documented under subsections (2) and (3) for at least one year, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

A Critical Incident Report (CIR) was submitted to the Director for a resident when an incident occurred which caused injury to the resident which resulted in a significant change in their health condition. The CIR indicated that the resident was discovered on the floor and had sustained an injury that required medical treatment. The resident was attempting to sit on their bed, when the bed moved from under them. The licensee’s investigation revealed that the safety feature to lock the wheels out on the bed was not enabled at the time of the fall.

During an interview a PSW indicated that the resident had received a new bed and when they attempted to sit on it, the bed slid out from under them resulting in the resident being injured. The PSW indicated that the wheels were not locked out to prevent the bed from moving. The PSW indicated that maintenance had not enabled the safety lock when they set the bed up.

During an interview Maintenance Manager (MM) #106 indicated that the home had received new beds and the Maintenance Worker (MW) was responsible to deliver and set them up in resident rooms. The new bed was delivered to the resident and the MW failed to apply the safety locks to prevent the bed from moving if it was leaned against. The MM indicated that this was an oversight for this particular bed. All other beds in the home were checked and all other locks had been properly applied.

Review of the manufacturers instructions for the Low Bed Model operating instructions indicated that directional lock hinge is to be applied to the caster to prevent lateral movement of the caster if the resident was to use the bed for support when getting in or out of the bed. Residents could be injured if the bed moves sideways, to guard against this you must engage "Directional Hinge Lock".

When the manufacturers instructions for the Low Bed Model operating instructions were not followed for locking the casters to prevent lateral movement of the casters, the resident was injured when they attempted to sit on the bed and it moved out from under them.

Sources: CIR, Use and Care Manual Low Bed Model, interview with PSW and MM [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident Report (CIR) was submitted to the Director for an incident that caused an injury which resulted in a significant change in the resident's health condition.

Review of the clinical records for the resident including the post falls assessment identified that resident #002's fall was unwitnessed, and there was an injury to the resident. An initial assessment of the resident including vitals signs was completed, there was no head injury routine (HIR) completed including a neurological assessment following the discovery of the resident until several minutes later. The clinical records also indicated that resident #002 experienced a specified number of additional unwitnessed falls and the HIR was incomplete for half of the falls and never initiated for the other half of the falls. There was no evidence to support that the Physician or Nurse Practitioner (NP) had ordered the HIR to be discontinued.

Expanded scope included a review of a fall CIR for resident #003 which identified a CIR was submitted to the Director for an incident that caused an injury to resident #003, for which resulted in a significant change in the residents health status. An initial assessment including vital signs and a neurological assessment indicating that further medical intervention was required. A second set of vital signs was documented but did not include a neurological assessment. There was no further documentation including a HIR for resident #003. Review of the clinical records for resident #003 indicated they had experienced an identified number of unwitnessed falls whereby HIRs were incomplete to varying degrees. There was no evidence to support that the physician or NP had ordered the HIR to be discontinued.

Review of the licensee's policy Fall Prevention & Management indicated the following: The registered staff will:
- Initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed and they are on anticoagulant therapy.
- Monitoring HIR for 48 hours post fall for signs of neurological changes, i.e. facial droop, behavioural changes, weakness on one side etc.
- Complete a Falls Incident Report under Risk Management in the computerized record; an associated progress note will be generated.

Review of the Post Fall Team Meeting paper assessment identified that if a fall is unwitnessed, a HIR must be completed. The assessment is to be completed every 15 minutes times four, then every 30 minutes times two, then every hour until stable. There was no documentation of a completed HIR.

During an interview RPN #113 indicated that that they would conduct a head injury routine post fall if the resident hit their head or a fall was not witnessed. The RPN indicated the HIR is documented on the post fall team meeting paperwork and the vital signs along with a neurological assessment are to be completed at interval as identified on the document. The RPN indicated the HIR was continued until the resident was determined to be stable. The RPN was unaware that the policy indicated the HIR was to be continued for 48 hours post fall.

During separate interviews the Director of Care and the Clinical Care Coordinator both indicated that the homes expectation is the policy will be followed, a HIR should be completed for 48 hours post fall to ensure the resident is monitored for signs of neurological changes, unless directed otherwise by the Physician or Nurse Practitioner.

Resident #002 and resident #003 were at risk when the post fall assessment including 48 hour head injury routine monitoring was incomplete following unwitnessed falls including falls with visible head injuries.

Sources: Critical Incident Reports, clinical records for residents #002, and #003, policy Fall Prevention & Management and staff interviews. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of abuse by two PSW's towards six identified residents. Review of the licensee's internal investigation records revealed that the abuse had been witnessed by multiple direct care staff and had occurred for a period of approximately three months without being reported.

Review of the 2020 training records for direct care staff who had received training relating to abuse recognition and prevention indicated that 27/51 PSW's and 9/16 Registered Staff had completed a review of the licensee's policy for abuse.

During interviews multiple direct care staff indicated they did not recall having received training relating to abuse recognition and prevention.

During an interview with the Director of Care, they were unaware that all direct care staff had not received training related to abuse recognition and prevention.

When all staff who provide direct care to residents had not received annual training relating to abuse recognition and prevention, the residents were at increased risk of being abused.

Sources: CIR, education records, staff interviews. [s. 221. (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 ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that when maintaining an emergency drug supply for the home, that a written policy was in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

A Critical Incident Report (CIR) was submitted to the Director for controlled substances missing/unaccounted for. The CIR indicated that two nurses witnessed that there were eight ampules of a specified controlled substance placed into the emergency drug box. The narcotic count sheets that were located in the narcotic binder did not reflect that eight ampules were added into the emergency drug box under the identified prescription number. During a shift count of the emergency drug box, it was discovered that there appeared to be eight ampules of specified controlled substance that could not be accounted for.

Review of the licensee’s internal investigation indicated that the home had been directed

by their pharmacy provider, to retain any unused specified controlled substance ampules that were no longer required for a resident, and to place these ampules into the emergency drug box, rather than destroy them, due to a shortage. Staff were retaining the unused prescriptions but were not logging them in to the emergency box count sheets by their individual prescription number. All ampules were being recorded under the initial prescription number for the emergency drug box, and as a result were not properly accounted for. Following the homes investigation, it was concluded that the specified controlled substance was never missing, it had not been recorded and accounted for by the prescription number rather it was added to the existing prescription in the emergency drug box.

Review of the licensee's pharmacy Emergency Drug Box policy indicated that the policy did not contain procedures for access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

During an interview the Director of Care (DOC) indicated that staff had not recorded correctly the ampules of the specified controlled substance that were added to the emergency drug box. The DOC indicated that after reviewing the pharmacy policy, it did not provide direction for the process to access the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply. The DOC also indicated that the home has changed Pharmacy providers and the new policies reflect the requirements.

The home was at risk for unaccounted controlled substances when they failed to ensure that a written policy was in place for the emergency drug supply met the requirements as indicated in O.Reg. 79/10, s.123.

Sources: licensee's internal investigation, related policies from the Pharmacy, observations, interview with RPN's and DOC. [s. 123. (b)]

Issued on this 5th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KARYN WOOD (601), SARAH GILLIS (623)
Inspection No. / No de l’inspection :	2021_885601_0014
Log No. / No de registre :	019998-20, 020895-20, 022332-20, 023749-20, 001015-21, 001402-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 23, 2021
Licensee / Titulaire de permis :	Trent Valley Lodge Limited 195 Bay Street, Trenton, ON, K8V-1H9
LTC Home / Foyer de SLD :	Trent Valley Lodge 195 Bay Street, Trenton, ON, K8V-1H9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Kelly Slawter

To Trent Valley Lodge Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:

1. All staff aware of potential or actual resident abuse must follow the abuse policy and procedures for reporting abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with when staff failed to report allegations of abuse towards six residents by two PSWs.

The licensee's Abuse and Neglect of a Resident - Actual or Suspected policy indicated that all staff members have an obligation to report any incident or suspected incident of resident abuse. If a staff member or volunteer become aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker they must notify the nurse of actual or suspected abuse. The nurse will notify the registered nurse in charge of the home and immediately notify the Director of Care/Administrator, the Director of Care or designate will immediately notify the MOHLTC Director.

Review of the licensee's internal investigation for allegations of abuse towards six residents by two PSWs, revealed that multiple staff in the home were aware of the ongoing abuse towards the residents and did not report it. A staff interviewed indicated they had witnessed the abuse towards the resident about

a month prior to the abuse investigation and they should have immediately reported what they had witnessed. They further indicated that the PSWs action towards the resident did not feel right and they were not clear if the PSWs actions would be considered abuse and reportable.

During an interview the DOC indicated that the home expectation is that all staff will follow the zero tolerance of abuse policy and will immediately report any alleged, suspected or witnessed abuse of a resident. The DOC confirmed that staff did not follow the policy.

When alleged, suspected, or witnessed abuse was not immediately reported by staff, the residents of the home were at actual risk of harm when the abuse continued for approximately three months before being reported.

Sources: Critical Incident Report, Abuse and Neglect of a Resident Policy, licensee's internal investigation, staff interviews. [s. 20. (1)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents when the emotional abuse continued for approximately three months before being reported.

Scope: The scope of this non-compliance was a pattern and involved six incidents of resident abuse.

Compliance History: One previous Written Notification and two previous Voluntary Plans of Correction were issued to the home under the same subsection of the legislation. (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must be compliant with s. 76 (4) of the LTCHA.

Specifically, the licensee must:

1. Educate all staff on the licensee's abuse policy and the Residents' Bill of Rights including:
-Mandatory reporting of abuse under s. 24(1) of any alleged, suspected or witnessed abuse.
-The definitions of abuse as defined by O. Reg 79/10, which include emotional, financial, physical, sexual, verbal abuse, and neglect.
-The relationship of power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

2. Keep a documented record of all education provided and staff attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff had received retraining annually related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 of the LTC Home Act.

Review of the licensee's annual education for 2020 was completed. The records indicated that 50.4% of the homes staff completed education on the home's policy to promote zero tolerance of abuse and neglect of residents, which has

embedded in it, the duty to make mandatory reports under section 24. There was no record of any annual education related to the Residents' Bill of Rights.

During interviews multiple staff indicated they had never received training or had not received training for approximately three years related to the homes abuse policy and they could not recall ever being educated on the Residents' Bill of Rights, and the duty to make mandatory reports under section 24 of the LTC Home Act.

During separate interviews the Administrative Assistant (Admin A) #145 and the Manager of Life Enrichment (LEC) #132 indicated in December 2020 there was a staff meeting and there was a discussion about the abuse policy. According to the meeting minutes, 49 staff including managers attended the staff meeting. The Admin A and LEC indicated the abuse policy was distributed to staff to complete their education as a read and sign, then return the sign off sheet. The LEC and Clinical Care Coordinator (CCC) #102 indicated that this was the only education in 2020 since the beginning of the pandemic and there has been no education for staff so far in 2021.

During an interview the Director of Care (DOC) indicated that in December 2020 all staff were provided with a copy of the homes abuse policy and were to complete a sign off sheet and return it, to indicate they had read and understood the policy. The DOC indicated that there was no follow-up to ensure that all staff returned the document and was unaware that 49.6% of the staff had not completed the read and sign education document. The DOC confirmed that the annual education did not include the Resident's Bill of Rights.

When staff were not educated annually related to The Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 of the LTC Home Act the residents were placed at risk of abuse and neglect as a result.

Sources: Education records, meeting minutes, staff interviews. [s. 76. (4)]

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents as residents could

possibly be placed in situations where staff members did not know how to safely react.

Scope: The scope of this non-compliance was widespread, as several staff members had not received the required annual training prior to performing their responsibilities.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

Service Area Office /
Bureau régional de services : Central East Service Area Office