Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
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Original Public Report

Report Issue Date: November 3, 2023	
Inspection Number: 2023-1065-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Trent Valley Lodge Limited	
Long Term Care Home and City: Trent Valley Lodge, Trenton	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19-21, 25-28, 2023 and October 3, 4, 2023

The following intake(s) were inspected:
- Intake: #00093711 - CIR #2337-000017-23, and Intake: #00096066 CIR #2337-000023-23 alleged neglect of resident by staff
- Intake: #00094267 - CIR #2337-000020-23, and Intake: #00095032 - CIR # 2337-000022-23 - Resident to resident alleged physical abuse.
- Intake: #00094642 - CIR #2337-000021-23 Misuse/Misappropriation of residents money.
- Intake: #00096697 - Complaint related to resident missing personal belongings.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their written policy related to zero tolerance of abuse and neglect of residents was complied with, for a resident. Specifically, staff did not comply with the licensee's Abuse and Neglect of a Resident – Actual or Suspected Procedure #VII-G-IO.OO; number two, Notify the Charge Nurse.

Rationale and Summary
On a specified date in August 2023, a resident reported their wallet and monetary property as missing to staff when the item could not be located in the pre-arranged locked storage.

A review of the resident’s progress notes on med-e-care was conducted. On specified dates in August, 2023, it was documented that a resident reported their wallet as missing to staff within the Long Term Care Home (LTCH). On a separate date in August, the resident’s Substitute Decision-Maker (SDM) reported the resident personal belongings as missing.

During an Interview with Personal Support Worker (PSW) #104, it was confirmed that the missing money should be considered suspected financial abuse and reported to the nurse in charge. During an interview with Charge Nurse #103, it was confirmed that this item was not reported as missing. During interviews with PSW #104, Charge Nurse #103, and Director of Care #101, it was confirmed the Abuse and Neglect of a Resident – Actual or Suspected Procedure was not followed.

A review of Charge Nurse #103’s report notes from a specified date in August 2023, included items to action, and issues arising from the day. There was no documentation of the missing personal belongings for the resident.

By not ensuring the written procedure related to Abuse and Neglect of a Resident – Actual or Suspected was followed. This may result in delay in investigation and actions taken.

Sources: Resident Progress Notes, Abuse and Neglect of a Resident – Actual or Suspected Procedure #VII-G-IO.OO; Interviews with PSW #104, RPN #103, and DOC #101. [741726]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by staff, that is reported to the licensee is immediately investigated.

Rationale and Summary:
Critical Incident Report (CIR) #2337-000021-23 indicated that a resident had experienced misuse/misappropriation of their money, when the resident's wallet went missing.

During an interview with the DOC #100 and Administrator #101, it was indicated that they were unable to find any documentation of an investigation having been completed related to this incident.

Failure to investigate an incident of suspected financial abuse, can lead to a delay in response and actions taken.

Sources: CIR #2337-000021-23, resident's health care record; interviews with PSW #104, DOC #101 and Administrator #100. [741726]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 4.

The licensee has failed to ensure that a person who had reasonable grounds to suspect Misuse or misappropriation of a resident's money, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary
On a specified date in August, 2023, a resident reported their wallet and monetary property as missing when the item could not be located in the pre-arranged locked storage.

A review of the resident's electronic progress notes, indicate the resident reported their belongings missing on specified dates in August, 2023. It is also documented that the SDM for the resident reported the property as missing on a separate date in August, 2023.

A review of CIR 2337-000021-23 indicated that the report was first submitted to the Director on a date in August, 2023, three days after the item was initially reported as missing.

During an interview with Administrator #100 and DOC #101, it was confirmed that the incident required immediate reporting to the Director and was not immediately reported.

The risk associated with not immediately informing the Director of suspected abuse, is that it could delay the investigation or appropriate follow-up.

Sources: CIS report #2337-000021-23, electronic progress notes for the resident, interviews with Administrator #100 and DOC #101. [741726]

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to ensure that their written skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions, was complied with, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written skin and wound care program for a resident is complied with. Specifically, staff did not comply with the licensee's Skin and Wound Care Management Protocol, #G-12.

1. The PSW will conduct a weekly skin surveillance of the resident's skin condition during hygiene and grooming and, for the first bath of each week, use the worksheet tool body diagram to record any reddened or discolored areas or skin breakdown related to pressure or injury and report to the registered staff.
2. Registered staff will transfer the information from the Weekly Skin Surveillance Tool and Worksheet to the resident's record following the instructions on the sheet

Rationale and Summary
According to the resident’s progress notes, they were identified on a date in July, as having an open area, that was not staged, and not previously reported. The wound required changes to the resident’s treatments.

During a review of the resident’s electronic and physical health records, weekly skin surveillance tools could not be located.

During an interview with RPN #105, it was confirmed the expectation for PSWs is to complete a skin assessment on the bath day and report any findings to registered staff. It was also confirmed that the

wound was not reported previously to registered staff. RPN# 105 advised the weekly skin assessment tool is not currently in use by registered staff.

Subsequent interview with PSW #104 confirmed the process within the home was for skin assessments to be distributed to staff and completed on a paper document by PSW staff on bath days. PSW #104 confirmed skin assessments had not been completed for the resident.

Administrator #100 and DOC #101 confirmed, in an interview, that there was no record of skin assessments from the PSW staff, or registered staff, and the current policy on skin assessments is not being complied with.

By not ensuring the written protocol related to Skin and Wound Care Management was complied with, the resident was at an increased risk of altered skin integrity.

Sources: Resident's electronic health record, Progress Notes, and assessment history; Skin and Wound Care Management Protocol, #G-12. Interviews with PSW #105, RPN #104, Administrator #100 and DOC #101. [741726]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale & Summary
According to the resident's progress notes, they were identified on a day in July, as having an open area, that was not staged, and not previously reported. The wound and required changes to the resident's treatments.

During a review of the resident's electronic and physical health records, wound assessments using a clinically appropriate assessment tool could not be located. Assessment of the wound was documented in a progress note on the date the wound was discovered. Inspector #741726 was unable to locate any subsequent wound care assessments.

During an interview, RPN #105 confirmed that staff do not always use a tool, to assess wounds, and will often use e-notes. During a subsequent interview with Administrator #100 and DOC #101, it was confirmed there is a weekly surveillance clinical monitoring tool available, however there was no record of the skin assessments being completed in physical or electronic records, when the change in the resident's skin integrity was noted.

There was an increased risk for wound deterioration when the resident's wound was not assessed by a registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Sources: Resident's progress notes, Treatment Administration Records, and interviews with RPN #105, Administrator #100, and DOC #101. [741726]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)

The licensee has failed to ensure that a resident was assessed by a registered dietitian who is a member of the staff of the home, when exhibiting a skin condition that was likely to require or respond to nutrition intervention.

Rationale and Summary.
According to the resident's progress notes, they were identified on a day in July, as having an open area, that was not staged, and not previously reported. The wound required changes to the resident's treatments.

During a review of the resident's electronic and physical health records, a referral to the dietitian could not be located.

During an interview with RPN #104, it was confirmed the process is to have the dietitian assess each resident, for every new wound. RPN #104 could not confirm if this had been completed. During interviews with Administrator #100 and DOC #101, it was confirmed there was no record of a dietitian referral being completed, and no assessment from a dietitian, when the resident exhibited a change in their skin integrity.

By not ensuring the resident was assessed by a registered dietitian who is a member of the staff of the home, when exhibiting a pressure injury, they were at risk for further wound deterioration.

Sources: Resident's electronic health record, Progress Notes, and assessment history; Interviews with RPN #104, Administrator #100 and DOC #101.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the complaint response provided to a person who made a complaint shall include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Rationale and Summary
A review of the CIR submitted on a day in August, indicated that a complaint was received by the LTCH on the same date. The LTCH responded to the complaint in writing on two days later, and again on the following day, but did not provide the contact information for the Ministry or the patient ombudsman.

During an Interview with Administrator #100 and Director of Care #101, it was confirmed that the contact information for the Ministry and patient ombudsman had not been provided to the complainant.

Failure to provide contact information for the Ministry and patient ombudsman could mean the complainant is unaware of the next steps to escalate the situation, this could impede the health, safety, and well-being of the residents.

Sources: CIR #2337-000021-23, LTCH complaint documentation, and interview with Administrator #100 and DOC #101. [741726]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that a documented record is kept in the home for each verbal or written complaint.

Rationale and Summary
On a day in August, a written complaint was received in relation to alleged financial abuse of a resident.

A request for the record of complaint was made to Administrator #100 and DOC #100.

During an interview with Administrator #100 and DOC #101, it was confirmed there was no evidence that a record had been maintained.

By not retaining a record of written or verbal complaints involving the care of a resident, it is unclear if actions were taken to resolve the concern. This could impede the health, safety, and well-being of the residents.

Sources: Interviews and Request for Information with Administrator #100, and DOC #101. [741726]