Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: January 4, 2024

Inspection Number: 2023-1065-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Trent Valley Lodge Limited

Long Term Care Home and City: Trent Valley Lodge, Trenton

Lead Inspector	**Inspector Digital Signature**
Cathi Kerr (641)	Cathi Kerr Digitally signed by Cathi Kerr Date: 2024.01.05 15:19:02 -05'00'

Additional Inspector(s)
Kayla Debois (740792)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18, 19, 20, 21, 22, 27, 2023

The following intake(s) were inspected:

- Intake: #00098707 - Complaint with concerns related to staffing shortages and resident care.
- Intake: #00099100 -CI# 2337-000028-23 - Fall of a resident resulting in injury.
- Intake: #00099842 - Complaint with concerns related to a resident's responsive behaviours.
- Intake: #00100442 - CI# 2337-000034-23 Staff to resident alleged neglect and abuse.

- Intake: #00101016 - Complaint with concerns about resident care.
- Intake: #00101142 - Complaint of alleged neglect related to a resident fall.
- Intake: #00101190 - CI# 2337-000037-23 related to injury of a resident of unknown etiology.
- Intake: #00101886 - CI# 2337-000038-23 related to alleged staff to resident abuse.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and

more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary:

Point of Care (POC) bathing documentation indicted that during two separate ten day periods, bathing activity did not occur for two residents.

During interviews with two PSWs, they stated there were times that residents' baths were not completed as scheduled when they were short staffed. In an interview with the Director of Care (DOC), they acknowledged that residents were to have baths twice weekly, and the two residents identified did not receive their scheduled baths during the specified periods.

The risk of residents not receiving their baths as scheduled can result in poor hygiene and skin breakdown.

Sources:
Clinical documentation review of residents' bathing records, interviews with PSWs and DOC, document review of staffing schedules. [740792]