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
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Original Public Report

Report Issue Date: February 26, 2024	
Inspection Number: 2024-1065-0001	
Inspection Type: Critical Incident	
Licensee: Trent Valley Lodge Limited	
Long Term Care Home and City: Trent Valley Lodge, Trenton	
Lead Inspector Carrie Deline (740788)	Inspector Digital Signature Carrie E Deline Digitally signed by Carrie E Deline Date: 2024.03.04 10:02:35 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6 - 8, 2024

The following intake(s) were inspected:

- Intake: #00105405 - CIS #2337-000001-24 Resident to resident alleged physical abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident current plan of care provides clear direction to staff and others who provide direct care to the resident.

Rationale & Summary

1. A resident was referred to the Behavioural Support Outreach team (BSO) for assistance with interventions in managing their behaviours.

A review of the resident's current plan of care indicated that they exhibited responsive behaviors but did not address all of their responsive behaviors.

During interviews with staff they confirmed that the resident had history of a number of responsive behaviours.

During an interview with staff, they confirmed that staff utilized interventions to manage the responsive behaviours in the past. The Inspector reviewed the written plan of care and the interventions identified by the staff were not identified in the current plan of care.

During interviews with staff they confirmed that staff are to take direction around behavioural interventions from the written plans of care and kardex located on the computer which does not provide clear interventions upon review.

2. On a specific date the resident was observed, by the Inspector, utilizing a falls preventions intervention.

A review of the resident's written plan of care did not indicate the use of this falls prevention intervention.

In an interview with staff, they confirmed that the resident does use a wheelchair but was unsure as to whether they required any falls interventions.

During interviews with staff, they confirmed that staff are to take direction around falls from the written plan of care and posted signs on the resident's closet doors. During these interviews they confirmed that the direction is not clear in the written plan of care regarding the current plan of care intervention.

By not ensuring the resident's care plan provided clear direction to staff placed the resident at risk of injury related to possible interventions not being implemented.

Sources: Review of resident's Plan Of Care, Behavioural care plan, hospital records, resident closet signs, Interviews with staff and resident observations.
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