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

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Public Report

Report Issue Date: February 19, 2025
Inspection Number: 2025-1065-0001
Inspection Type: Complaint Critical Incident
Licensee: Trent Valley Lodge Limited
Long Term Care Home and City: Trent Valley Lodge, Trenton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11, 12, 14, 18, 19, 2025

The following intake(s) were inspected:
Intake: #00136153 - CIR #2337-000002-25 - Alleged resident to resident physical abuse.
Intake: #00136590 - Complaint related to resident care concerns.
Intake: #00136735 - CIR #2337-000003-25- Alleged resident to resident sexual abuse.
Intake: #00139454 - CIR #2337-000005-25 - Related to a resident missing for less than three hours.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

Staffing, Training and Care Standards

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 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that when care set out in a resident's plan of care was not effective, different approaches were considered.

A resident was found wandering outside on two separate occasions. No changes had been made to the resident's plan of care when the resident had demonstrated the ability to leave the unit unattended.

Sources: Resident's health care record, including care plan and progress notes, interviews with staff and the Director of Care.

WRITTEN NOTIFICATION: 24 hour Nursing Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)
Nursing and personal support services

s. 11 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to ensure that at least one registered nurse was on duty and present in the home at all times.

The Inspector reviewed the licensee's Daily Staffing Sheets between January 1, 2025 and February 18, 2025, that documented which registered nurse (RN) was working on each shift. It was noted that there was no RN working during the night shift on the following dates: January 7, 8, 9, 13, 14, 16, 17, 18, 22, 23, 26, 30, and February 9, 2025.

Sources: Daily Staffing Sheets and interview with the DOC.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 4.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

The licensee has failed to ensure that the Director was immediately informed when a resident was missing from the home and returned with an injury.

A review of the Critical Incident System indicated that there had been no critical incident submitted to the Director by the licensee, related to a resident having eloped from the home, returning with an injury.

Sources: Critical Incident review and interview with the Director of Care.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of COVID had been declared in the home.

A review of the Critical Incident System indicated that there had been no critical incident submitted to the Director by the licensee, related to a COVID outbreak in the home, that had been declared by public health on January 24, 2025.

Sources: Critical Incident review and interviews with the Director of Care and IPAC Lead.