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: January 23, 2026
Inspection Number: 2026-1065-0001
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): January 12-14, 19-23, 2026

The following intake(s) were inspected:
-Intake: #00164414 - CI #2337-000050-25 - Missing resident.
-Intake: #00164553 - CI #2337-000051-25 - Alleged resident to resident Sexual abuse.
-Intake: #00164752 - Complaint received with concerns regarding alleged resident to resident sexual abuse.

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

Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

"sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specific day in December, 2025, a specific resident was witnessed by staff allegedly sexually abusing a second resident. Interviews with staff confirmed prior to the incident, the resident was demonstrating an increased interest with the second resident, which staff found concerning due to the resident's prior history of sexual abuse. Staff confirmed during interviews, upon discovering the second resident during the alleged abuse, the resident was displaying non-verbal cues indicating agitation or distress.

Interviews with several staff members confirmed that the second resident would not be capable of providing consent to sexual acts, as well as physical and cognitive barriers that would limit the resident from stopping an unwanted act.

Sources: Resident's progress notes; Abuse and Neglect of a Resident - Actual or Suspected Policy #G-1 (September 2025); Interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A specified resident had a known history of sexual abuse with known triggers requiring them to be moved to another unit to mitigate re-occurrence.

On a specific day in December, 2025, a specific resident was witnessed by staff allegedly sexually abusing a second resident. Interviews with staff confirmed prior to the incident, the resident was demonstrating an increased interest with the second resident, which staff found concerning due to the resident's prior history of sexual abuse. Staff confirmed there was a known history of this behaviour and pattern, however no triggers listed within the written plan of care.

Interventions listed within the resident's written plan of care included hourly safety checks, however Point of Care (POC) documentation requires safety checks to be completed every 30 minutes. In December, 2025 there was 135 missing entries noted within POC.

Inspector could not locate any behavioral assessments, or reassessments for the resident following this incident. Interviews with staff and BSO Lead confirmed a Dementia Observation System (DOS) is required for any resident experiencing new, or increased behaviours. Inspector could not locate a DOS following the incident in December, 2025. Behavioural Supports Ontario (BSO) Lead confirmed a DOS was required to be completed, and was not.

Sources: Review of residents progress notes, written plan of care, and Documentation Survey Report (December, 2025); Responsive Behaviours Policy #F-5 (June, 2025); Lack of behavioural assessments including DOS for December, 2025; Interviews with BSO Lead and other staff.