Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 25, 26, 27, 28, 2012	2012_041103_0022	Complaint

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street, TRENTON, ON, K8V-1H6

Long-Term Care Home/Foyer de soins de longue durée

TRENT VALLEY LODGE LIMITED
195 BAY STREET, TRENTON, ON, K8V-1H9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Personal support workers, Registered Nurses, Registered Practical Nurses, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed resident care and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 3(1)1 in that a resident's rights were not respected.

Resident#1 is deemed to be capable of making his/her own decisions.

During the complaint inspection, Resident#1's progress notes were reviewed and the following entries demonstrated examples that the resident's rights were violated:

-On six identified dates, the night shift progress notes indicated Resident#1 rang his/her call bell and requested to get up. On each occasion, staff advised the resident they were doing rounds and would be unable to get the resident up until after rounds were completed.
-On another identified date, Resident#1 rang the call bell on nights on more than one occasion and requested a sandwich. Staff advised the resident that his/her blood sugar was high and that the nurse in charge did not want the resident to eat at this time. There was no indication the resident's blood sugar levels were reassessed on the night shift or that the resident received counselling in regards to alternative food choices.
-On another identified date, the progress notes indicated the resident was ringing repeatedly. The staff documented the resident was verbally abusive and pointed his/her finger in the staff member's face. The staff member advised the resident they were not there to take his/her abuse and needed to calm down.
2. Resident#1 contacted the Advocacy Centre for the Elderly (ACE) and stated he/she was not being allowed to leave the home without supervision.

Resident #1 was interviewed and stated he/she is now able to go outside unaccompanied but has agreed to stay on the home's property because of safety risks identified by the home and family members. The resident states this is acceptable.

Resident #1 confirmed he/she was often told he/she could not get up on nights until after rounds were completed and at times the resident was denied the ability to make decisions related to dietary choices.

The Director of Care (DOC) stated at times when Resident#1 does not comply with the medications, he/she becomes irrational and believes during those times the resident is incapable of making appropriate decisions that may jeopardize his/her safety and well being.

The DOC stated it was her expectation that staff would be available on nights throughout rounds to respond to the resident's request to get up and that all resident's have the right to make choices in regards to their dietary intake.

PSW staff #100 and #101 were interviewed in regards to a resident with a high blood sugar requesting desserts or snacks. Both advised they would counsel a resident and suggest a healthier choice, but indicated it was ultimately the resident's right to make the choice.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure Resident#1's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and dignity is upheld, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (1)(c) by not providing clear directions to staff who provide care to the resident.

Resident #1 has poorly controlled Diabetes Mellitus. The plan of care for "Alteration in Nutrition-Diabetes" indicates "reinforce a modified diet". There are no additional interventions or strategies to assist staff.

Resident #1 exhibits behaviors secondary to his/her diagnosis. The plan of care indicates "verbal expressions of distress" and the interventions and strategies state, "be consistent with approach and involve resident in the decision making". There are no additional interventions or strategies to assist staff.

Issued on this 3rd day of July, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs