Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017	2017_603194_0008	003314-17	Critical Incident System

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 13 and 14, 2017

CI inspection Log # 003314-17 related to allegations of resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

Also completed was a review of the identified residents clinical health records and of the licensee's abuse policy. Observed resident to resident interactions as well as staff to resident provision of care.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(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. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee shall ensure that resident #001 is reassess and the plan of care reviewed and revised when the care set out in the plan has not been effective, and have different approaches considered in the revision of the plan of care.

The current plan of care for resident #001 related to identified responsive behaviour:
-checks every 15 minutes to monitor and discourage behaviours
-accept the residents responsive behaviours and do not react to it, speak in a calm, firm and reassuring manner at all times.
-always approach resident from the front
-be clear regarding treatment expectations and consequences regarding responsive behaviour
-decrease environmental stimulation, turn lights down low
-do not invade personal space
-encourage resident to verbalize feelings and explain the effect the behaviour has on others
-if resident is agitated when staff approach for care, leave and return at a later time
-maintain a regular routine
-monitor for signs of anger or distress, use behaviour sheet to track incidence
-never argue or deny feelings, thoughts or beliefs
-provide resident with time for 1:1 talking in order to decrease incidence of responsive behaviours
-remove anyone that may be in danger from the area
-remove resident from any stressful situation
-staff to be aware of the responsive behaviour and have extra staff help with care

On an identified date resident #001 is witnessed by PSW #100 exhibiting responsive behaviour towards resident #002. PSW #100 indicated during interview with inspector that resident #002's reaction to the responsive behaviour was, oh, oh, oh. Resident #002 was assessed by PSW #100 upon return to the resident's room.

The following day resident #001 is witnessed by PSW #100 exhibiting responsive behaviour towards resident #003 During interview RN #104 indicated that resident #003 was not injured as a result of the behaviour.

Six days later resident #001 attempted the responsive behaviour towards resident #002, staff intervened and there was no injury.

Review of the DOS assessment in place for resident #001 for a period of seven days was completed by inspector #194. The DOS charting indicated that resident #001 was exhibiting responsive behaviours on two of the dates where incidents were described.

During interview ADOC indicated being responsible for reviewing the DOS charting and initiating changes required. ADOC indicated during same interview that DOS charting for resident #001 had been reviewed but no action had been taken at this time. ADOC indicated that physician had completed a medication review for resident #001 but did not want to make any changes until recommendations from the external assessment was completed.

The plan of care for resident #001 has been updated to reflect to use of 1:1 if required as directed by DOC since the first documented incident. During an interview DOC has indicated that 1:1 monitoring has only been available for resident #001 on one specific day for a period of 8 hours. No other interventions have been initiated related to the behaviours. DOC was unable to verify if a referral for the external assessment of resident #001 had been completed.

The licensee failed to review and revise the plan of care for resident #001 related to the DOS assessment and progress notes completed for the period of seven days related to the two incidents of responsive behaviour and one incident of attempted responsive behaviour. [s. 6. (11) (b)]

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 by ensuring that when a resident is reassessed the plan of care is reviewed and revised with necessary modifications, with respect to the reassessment and revision, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The Licensee's abuse policy "Abuse and Neglect of a resident -actual or suspected "VII-G-10.00" dated January 2017 directs;

reportable matters include:
-any incident with respect to alleged, suspected or witnessed abuse or a resident by anyone or alleged, suspected or witnessed neglect of a resident by the home or staff.
-all staff members have an obligation to report any incident or suspected incident of resident abuse and further, if a staff member is found guilty of not having reported such an incident, he/she will be severally reprimanded and/or terminated.

The charge nurse will:
1. safeguard the resident immediately - assess injuries, provide medical interventions if indicated
2. notify the RN in charge of the home
3. immediately notify DOC/Administrator
4. review MOHLTC reporting decision tree
5. initiate the Nursing checklist for reporting and investigating alleged abuse
6. assess and evaluate injuries and document each shift for a minimum of 72 hours post incident.

On an identified date an incident of physical abuse between resident #001 and resident #002 was witnessed by PSW #100 . PSW #100 reported to RPN #101 that resident #001 had been physically abusive towards resident #002.

RPN #101 indicated being in the charge nurse on the unit. RPN #101 indicated in the same interview of not being aware of the incident of physical abuse between resident

#001 and resident #002 until the end of the shift when asked by RN# 103 to complete a statement of the incident.

Review of the progress notes for resident #001 documented by RPN #101 indicated that on the identified date prior to the end of the shift resident #001 had been physically abusive towards a co resident.

RPN #101 indicated to inspector #194 during same interview, of not being able to recall if assessment of resident #002 was completed at the time of the incident.

The licensee's abuse policy was not complied with when RPN #101 did not immediately assess resident #002 after a reported incident of physical abuse or immediately notify the charge RN of the incident.

Non compliance for will be issued as a WN for LTCHA, 2007, s. 20, during this inspection. The licensee has an existing Compliance Order in place for the time of the identified incidents. The findings identified during this inspection, further support the Compliance Order under LTCHA, 2007 s. 19 (Duty to Protect), issued in Inspection #2017_603194_0004 which is to be in compliance by May 5, 2017. [s. 20. (1)]

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.