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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 23, 2023	
Inspection Number: 2023-1065-0002	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Trent Valley Lodge Limited	
Long Term Care Home and City: Trent Valley Lodge, Trenton	
Lead Inspector Sheri Williams (741748)	**Inspector Digital Signature**
Additional Inspector(s) Julie Dunn (706026) Catherine Ochnik (704957) Rexel Cacayurin (741749)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 5-10, 13-16, 2023 with February 10, 2023, conducted off-site.

The following intake(s) were inspected:
Intakes #00007006, #00007168 and #00007356-Follow up to Compliance Orders (CO) related to air temperature records.
Intake #00007007 – Follow up to CO related to hand hygiene.
Intakes #00001323, , #00012322 related to responsive behaviours.
Intakes #00002437, #00001278, #00003422, #00003091, #00007693 related to allegations of abuse.
Intake #00016844 related to an unexpected death.

The following intake was completed in this Complaint Inspection:
Intake #00012405- Concerns with malnourishment, dehydration, transferred to hospital end of life care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1065-0001 related to O.Reg. 246/22, s. 24 (2) inspected by Catherine Ochnik (704957)

Order #002 from Inspection #2022-1065-0001 related to O.Reg. 246/22, s. 24 (3) inspected by Catherine Ochnik (704957)

Order #003 from Inspection #2022-1065-0001 related to O.Reg. 246/22, s. 24 (5) inspected by Catherine Ochnik (704957)

Order #004 from Inspection #2022-1065-0001 related to FLTCA,2021, s. 102 (2) (b) inspected by Rexel Cacayurin (741749)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident falls, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a resident fall resulting in an injury.

The homes' fall prevention and management policy directs if a resident falls, they are not moved prior to the completion of an assessment for injuries; and if there is suspicion or evidence of injury, the resident should not be moved, and they should arrange for immediate transfer to the hospital.

Registered staff confirmed that an assessment was not completed prior to moving the resident, and reported they suspected the resident had injuries. When four staff lifted the resident, they were unable to weight bear and favouring their right leg. The resident was transferred to hospital where they were assessed to have an injury.

A RPN and the Director of Care (DOC) acknowledged that an assessment was expected to have been completed, and that the resident should not have been moved prior to transfer to hospital.

In failing to complete an assessment the resident was not assessed for injuries prior to being moved, which resulted in an increased risk of further injury and pain.

Sources:
Critical Incident Report(CIR), Fall Prevention and Management Policy, resident clinical record, interviews with staff and DOC.

[741748]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary:

A CIR was submitted to the Director related to resident’s fall resulting in an injury The resident was heard screaming and was found on the floor in their bedroom. Four staff manually lifted the resident to their feet. The resident was unable to weight bear and favouring their right leg. They were transferred to hospital and assessed to have a fractured pelvis.

The homes’ policy indicated residents who are non-weight bearing will be transferred by mechanical lift to prevent injury. Registered staff stated they were aware of the home’s policy requiring them to use a mechanical lift.

An RPN and the DOC reported the expectation was that staff were to have used a mechanical lift to transfer the resident from the floor to prevent injury to the resident.

When staff failed to use safe transfer techniques for the resident post fall, there was risk for further injury.

Sources:
CIR, Zero Lift Policy, Lift Procedures Policy, Fall Prevention & Management Policy, resident clinical records, interviews with staff and DOC.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.1

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, dated April 2022 (IPAC Standard), section 10.1 states, the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

While conducting a tour of the home the inspectors found portable and wall mounted Alcohol Based Hand Rub (ABHR) dispensers with expired ABHR products in all home areas including dining rooms, and unit bathrooms.

The DOC stated that the effectiveness of expired ABHR was not guaranteed in killing bacteria and viruses.

The home's Public Health Liaison confirmed that expired ABHR should not be used in the home.

Using expired ABHR products may increase the risk of transmission of infectious agents in the home.

Sources:
Interviews with DOC and Public Health Liaison, Observation.

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WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:

A CIR was submitted to the Director, alleging neglect of a resident, related to a resident missing a dose of a medication prescribed for their health condition. The resident was to receive the medication every three weeks on a Friday. A nurse found the medication that was to be administered in the medication refrigerator, and a staff member indicated they signed off on the medication but forgot to administer it.

An RPN and the DOC confirmed the dose of medication was missed being administered and discovered three days after it was due.

When the resident did not receive their medication as prescribed, they were at risk of exacerbation of a chronic health condition.

Sources:
Residents clinical notes, interviews with staff and the DOC.

[706026]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (1) (a)

The Licensee failed to ensure that a missed dose of medication for a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary:

A CIR was submitted to the Director, alleging neglect of a resident who was missing a dose of a medication prescribed for their health condition An RPN and the DOC confirmed the medication was not administered as prescribed to the resident and it was discovered that the medication had been missed three days after it was due.

The DOC was unable to locate a medication incident report for the missed dose of medication for the resident. The Pharmacist searched the archives and was unable to locate a medication incident report related to the missed medication. An RPN and the DOC indicated that for a medication incident, including a missed dose, there should have been an online incident report completed. The DOC indicated that when staff submit an online medication incident report, it would automatically be sent to the pharmacy and the DOC.

Failing to document the medication incident resulted in no record of the medication incident and no record of reviewing the medication incident.

Sources:
Clinical records of the resident, interviews with staff and the DOC.

[706026]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee failed to ensure an allegation of abuse of a resident was immediately reported to the Director.

Rationale and Summary:

A CIR was submitted to the Director, alleging neglect of a resident by staff. The CIR indicated the resident was found wet by the complainant. It was reported to the Registered Staff that the resident had not been changed since the previous evening. The Registered staff did not pass the message on to the direct care staff. A few hours later, it was reported that resident's continence product had still not been changed. At that time, the Registered staff provided care for the resident, and completed an assessment. The Registered staff provided an apology to the resident.

The DOC indicated they were short staffed at the time, which resulted in care not provided for the resident. The Registered staff was notified by the complainant that care had not been provided for the resident. They did not communicate this information to other staff, which further delayed the resident's care. The DOC confirmed they would consider this to be neglect.

In an interview, the DOC indicated that the ministry's after-hours phone number is posted in all nursing stations and confirmed that the incident should have been immediately reported.

In failing to immediately report an allegation of neglect of a resident, there was low risk to the resident.

Sources: Clinical records, LTCH Internal Concern/Complaint Form, CIR, interview with the DOC.

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WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with LTCHA, 2007, s. 19 (1) under the Long-Term Care Homes Act (LTCHA), 2007 and FLTCA, 2021, s. 24 (1) under the Fixing Long-Term Care Act, (FLTCA), 2021.
On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of LTCHA, 2007. Non-compliance also occurred after April 11, 2022, which falls under s. 24 (1) of FLTCA, 2021.

Non-compliance with: LTCHA 2007, s. 19 (1)
1. The licensee failed to ensure that a resident was protected from neglect by staff.

Section 5 of the Ontario Regulation 79/10 defined neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary:

A CIR was submitted to the Director alleging neglect of a resident by staff. The CIR indicated that it was reported to the Registered staff by a complainant, that a resident was discovered to be wet and had not been changed since the previous evening. The Registered staff did not pass the message on to the direct care staff. A few hours later, it was reported the resident's continence product had still not been changed. At that time, the Registered staff provided care for the resident, including an assessment.

The DOC indicated they were short staffed at the time, which resulted in care not provided for the resident. It was reported to the Registered staff that care had not been provided for the resident, but they did not communicate this information to other staff, which further delayed the resident's care. The DOC confirmed that they would consider this to be neglect.

In failing to protect the resident from neglect, the resident was at increased risk of alteration in skin integrity.

Sources: Licensee’s Internal Complaint Form, resident clinical records, Interview with the DOC.

[706026]

Non-compliance with: LTCHA, 2007, s. 19 (1)
2. The licensee failed to ensure that a resident was protected from verbal and physical abuse by staff.

Section 2 of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Section 2 of the Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary

A CIR was reported to the Director related to an allegation of staff to resident abuse. A complainant reported they overheard a PSW using a raised voice and inappropriate language towards a resident while providing care. A skin tear to the resident’s right forearm resulted when the PSW tried to remove the resident ’s hand away from them.

The home’s investigation documents revealed that the resident’s behavior escalated by continuously grabbing the staff member’s hand at the time of incident. The investigation documents revealed that the PSW admitted the skin tear resulted when they removed the resident’s hands away from their wrist and confirmed that they yelled to the resident while attempting to provide care.

The DOC confirmed the incident was determined to be intentional and the outcome of the investigation determined that the allegation of abuse was founded.

Failing to protect a resident from physical and verbal abuse by staff resulted in moderate impact to the resident’s safety, dignity, and quality of life.

Sources:
Interview with DOC, licensee’s Internal Investigation binder, clinical notes.

[741749]

Non-compliance with: FLTCA, 2021, s. 24 (1)
3.The licensee failed to ensure that a resident was protected from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Rationale and Summary:

A CIR was submitted to the director alleging a staff to resident neglect incident. In interview by the Inspector, staff indicated on a specified date, approximately 15 to 30 minutes after the evening shift started, they entered the resident’s room and found the resident sitting in a wheelchair with a wet bath sling and wet towel underneath them. The resident had no shorts on and had nothing covering their bare legs. It was estimated that the resident was sitting like that for 30 to 45 minutes and the resident told the PSWs they were uncomfortable and angry.

Information provided in the home’s investigation file indicated that there was no communication from the staff on the outgoing day shift regarding the resident waiting to be dried and dressed after their bath, and the PSW staff found the resident in their room 30 minutes after the evening shift started.

The DOC indicated the licensee’s expectations were for the bath aide to communicate to the PSWs when a resident’s bath is completed, and the PSWs should dry and dress the resident. In an interview with the inspector, the DOC confirmed this was resident neglect.

Failing to protect e resident from neglect resulted in the resident being uncomfortable and angry, and increased the risk of skin breakdown for the resident.

Sources:
Licensee’s internal investigation file, interviews with staff and the DOC.

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Non-compliance with: FLTCA, 2021, s. 24 (1)
4. The licensee failed to ensure that a resident was protected from physical abuse by staff.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

Rationale and Summary:

A CIR was submitted to the Director related to a witnessed incident of staff to resident abuse.

On the evening of the incident, a Registered staff heard the resident screaming. When interviewed by the Inspector, the registered staff indicated they entered the resident's room and witnessed a PSW forcefully turning the resident on their bed while changing the resident's continence product. The resident was resisting and using their hands to attempt to cover themself. The registered staff intervened and asked the PSW to let go of the resident and leave the room. When assessing the resident after the incident, the Registered staff noted the resident was unsettled and they consoled the resident. The RPN indicated that a mark on the right side of the resident's face appeared to be an imprint of the control buttons for the bed, from when the resident was turned onto their side by the PSW with force, and the resident's face was pushed against control buttons.

Progress notes indicated the PSW was seen lifting the resident during the incident, with the resident pinned under the PSW's arm.

When interviewed by the Inspector, the DOC confirmed that it was a witnessed incident. The Registered staff heard the resident scream and saw the PSW forcefully turning the resident on their bed with the resident resisting. The Registered staff told the PSW they cannot force care, and the PSW was escorted off the property.

In interviews with the Inspector, the Registered staff, and the DOC both confirmed that abuse had occurred.

Failing to protect the resident from physical abuse resulted in a mark on the resident's face and the resident being unsettled.

Sources:

Clinical notes for resident, Licensee's internal investigation file, Interviews with staff and DOC.

[706026]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg 79/10 s. 51 (2) (b)

The licensee has failed to ensure that the individual plan of care related to continence for a resident was implemented

A CIR was submitted to the Director for an allegation of neglect related to a complainant finding a resident with their clothing soaked in urine.

The plan of care for the resident's continence care directs staff to check and change their incontinent product every morning, every evening, before meals, after meals and as needed.

In an interview the PSW stated they were busy and did not do the resident's care until after breakfast. Investigation documents indicated that despite the PSW saying they were busy it was considered neglect. In an interview, the DOC confirmed the allegation of neglect was substantiated.

Failing to ensure the individualized plan to promote resident's continence was implemented for the resident resulted in discomfort and potential for skin breakdown.

Sources: CIR, investigation notes, interviews with staff and DOC.

[741748]