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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Sep 2, 2015	2015_258519_0029	013621-15	Critical Incident System

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

SHERRI GROULX (519)

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): September 1, 2015

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Resident Care, three Personal Support Workers, and the Resident.

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

During the course of this inspection, Non-Compliances were issued.

- **1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee shall ensure that the following rights of residents were fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff.

According to the documentation, a Resident was dependent on staff for their personal care needs.

On a specified date and time, a direct care provider went into a Resident's room to check in on the Resident at the beginning of their shift. The direct care provider noted that the Resident was resting on the bed with the covers on.

The direct care provider returned at a later time to the Resident's room to provide care. They found the Resident was still on a personal assistive device left by the prior shift. This was reported to Management who immediately initiated an investigation. The investigation revealed that the Resident had been left on a personal assistive device by the previous shift direct care provider and had been left on it for a lengthy period of time.

According to investigation notes, the direct care provider had placed the Resident on the personal assistive device towards the end of their shift. The direct care provider admitted that they did not follow proper protocol reporting off to the next shift when they left for the day.

According to the progress notes, the Resident sustained mild injuries as a result of being left on a personal assistive device for a lengthy period of time. These mild injuries eventually subsided four days later.

Upon interview with the DORC on a specified date and time, it was confirmed that it was the home's expectation that a direct care provider would report to another direct care provider or a Registered Staff that they left a Resident on a personal assistive device when completing their shift. It was confirmed by the DORC that it was neglectful when the Resident was left on a personal assistive device for a lengthy period of time by a direct care provider resulting in mild injury. [s. 3. (1) 3.]

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 that the following rights of residents are fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 2nd day of September, 2015

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

Original report signed by the inspector.