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 prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2019	2019_755728_0004	027796-17, 027798-17, 027819-17, 000162-18, 001773-18, 003151-18, 017553-18, 019740-18, 022001-18, 023422-18, 025378-18, 029857-18, 030264-18, 001501-19, 003505-19	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

MARIA MCGILL (728), AMANDA COULTER (694), AMANDA OWEN (738)

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 11-15, 19-22, 25-26, 2019.

The following intakes were completed in this critical incident inspection:
Log# 017553-18, related to falls prevention and management;
Log #000162-18, related to falls prevention and management;
Log #030264-18, related to falls prevention and management;
Log #019740-18, related to falls prevention and management;
Log #027798-17, related to prevention of abuse and neglect;
Log #027819-17, related to prevention of abuse and neglect;
Log #027796-17, related to medication management;
Log #025378-18, related to falls prevention and management;
Log #029857-18, related to an injury that resulted in a significant change;
Log # 003151-18, related to prevention of abuse and neglect;
Log # 022001-18, related to an injury that resulted in a significant change;
Log # 003505-19, related to an injury that resulted in a significant change;
Log # 001773-18, related to an unexpected death;
Log # 001501-19, related to improper care of a resident; and,
Log # 023422-18, related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer (COO), the Director of Resident Care (DoRC), the Assistant Director of Resident Care (ADoRC), the Physician (MD), the Clinical Auditor, the Physiotherapist (PT), the Resident Assessment Instrument (RAI) Coordinator, the RAI back-up, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, and residents.

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, the home's investigative notes and documentation, and relevant meeting minutes.

Observations were made of relevant residents and staff, the facility and equipment, the provision of care, and medication count and administration.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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	Légende 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under section 48 of this Regulation that included relevant policies and provided for methods to reduce risk and monitor outcomes. Specifically, staff did not comply with the home's "Head Injury" policy, last reviewed April 2018, which was part of their falls prevention and management program.

The home's policy, titled "Head Injury", directed registered staff to complete a Head Injury Routine (HIR) when a resident had fallen and hit their head from a fall or the fall was unwitnessed. The policy directed staff to complete specified tasks at identified time intervals.

A) The home submitted a Critical Incident System (CIS) report stating that resident #007 had an unwitnessed fall on an identified date.

Resident #007's plan of care documented that the resident had a potential head injury.

Director of Resident Care #101 and Registered Nurse #113 said that a HIR was to be completed when a resident had fallen and hit their head from a fall or the fall was unwitnessed. DoRC #101 stated that the HIR for resident #007 was to be documented on a HIR Template.

A review of the HIR Template completed for resident #007 in response to their fall, showed that the resident had not been assessed according to the home's "Head Injury" policy. Specifically, the resident did not have their vital signs checked or their pupils, level of consciousness, motor response or condition assessed by a registered staff at two identified intervals. DoRC #101 said that the HIR was not completed in full as required.

B) The home submitted a CIS report that documented an unexpected death of resident #014.

Resident #014's progress notes documented that the resident had a witnessed fall on an identified date and that they would require the head injury routine to be completed.

The DoRC #101 and RN #113 said that a HIR was to be completed when a resident had fallen and hit their head from a fall or the fall was unwitnessed. Clinical Auditor #103 and DoRC #101 said that the HIR was to be completed when a resident was sleeping, unless they refused or checking would cause increased agitation that may pose more risk to the resident.

The HIR for resident #014 was initiated following the fall as per the home's policy and the related physician orders for this resident. However, the HIR was not completed as required at identified times. Resident #014's plan of care did not document a reason why the HIR was not completed.

DoRC #101 said that the head injury routine was not completed as required.

The licensee has failed to ensure that the home's "Head Injury" policy regarding completing HIR when resident #007 and #014 had fallen was complied with. [s. 8. (1) (a),s. 8. (1) (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 to ensure that relevant policies and provided for methods to reduce risk and monitor outcomes, specifically, related to the "Head Injury" policy, which was part of their falls prevention and management program, is complied with, to be implemented voluntarily.

Issued on this 22nd day of March, 2019

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

Original report signed by the inspector.