Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Oct 1, 2020	2020_798738_0023	012392-20, 013279-20, 014535-20, 014536-20, 016139-20, 018189-20	Follow up

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

AMANDA OWEN (738), JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 22-25, 2020.

The following intakes were completed during this Follow up inspection:

- Log #014535-20, related to compliance order (CO) #001 from inspection #2020_792659_0011, related to immediately reporting incidents of alleged, suspected, or witnessed abuse;
- Log #014536-20, related to CO #002 from inspection #2020_792659_0011, related to safe transferring and positioning;
- Log #013279-20/Critical Incident (CI) #2580-000014-20 and Log #018189-20/CI #2580-000029-20, related to alleged staff to resident abuse;
- Log #012392-20/CI #2850-000012-20, related to responsive behaviours; and
- Log #016139-20/CI #2580-000024-20, related to registered nurse staffing.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director of Care, Physiotherapy Assistant, RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspector(s) also toured the home, observed resident care provision, and completed record reviews.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2020_792659_0011	738
O.Reg 79/10 s. 36.	CO #002	2020_792659_0011	738

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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

The licensee has failed to comply with the following requirement of the LTCHA: it was a condition of every licensee that the licensee shall comply with every order made under this Act.

On September 1, 2020, CO #002 from inspection #2020_792659_0011 was issued under s. 36 of the Ontario Regulation 79/10:

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee shall ensure that:
a. Staff follow the manufacturer's instructions when the bath lift chair is used for a resident transfer.
b. Staff follow the home's lifts and transfers policy, related to ensuring two staff are present throughout the entire transfer when a bath lift is being used.
c. Staff follow the resident's plan of care related to the level of assistance required for the resident's transfer.

The compliance due date was September 1, 2020.

The licensee completed steps a and b in CO #002.

The licensee failed to complete step c.

A resident's plan of care was not followed during a transfer. There was no harm to the resident involved.

Sources: observation, progress notes, care plan, kardex, Achieva Physiotherapy Quarterly Re-Assessment, and staff interviews.

Issued on this 2nd day of October, 2020

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

Original report signed by the inspector.