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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 11, 2021	2021_796754_0019 (A1)	006920-21, 008497-21	Complaint

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

Amended by TAWNIE URBANSKI (754) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This licensee inspection report has been revised to reflect changes related to incorrect documentation. The Complaint inspection #2021_796754_0019, was completed on August 11, 2021.

A copy of the revised report is attached.

Issued on this 11st day of August, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by TAWNIE URBANSKI (754) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 21-25, 28-30, July 2, 5-9, 12, 2021.

The following intakes were completed during this complaint inspection:

Log #006920-21, a complaint related to infection prevention and control practices, and resident's rights,

Log #008497-21, a complaint related to improper care of a resident.

Amy Abbot, Inspector #694420 and Janis Shkilnyk, Inspector #706119 were present for this inspection.

NOTE: A Written Notification and Compliance Order related to O. Regulations 79/10, r. 36 was identified in this inspection and has been issued in a concurrent inspection, #2021_796754_0018, dated July 20, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Control Lead, Behavioral Specialist (BSO) Registered Nurse (RN), Social Worker, Registered Practical Nurse (RPN), and Personal Support Worker.

The inspector(s) also toured resident home areas, observed resident care provision, resident to staff interactions, and reviewed relevant resident clinical records and IPAC practices.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services

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

2 WN(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #011 collaborated with each other when developing and implementing the resident's plan of care so that the different aspects of care were integrated and consistent with and complimented each other.

A complaint was received by the Director related to resident #011 being restricted from leaving the home's property for specified reasons when they desired.

An assessment was completed for resident #011 that documented the resident was safe to leave the home's property independently for specified reasons.

DOC #101 created a schedule for resident #011 to leave the home's property for specified reasons. The schedule documented that the resident could only leave the home's property three to four times per day for 15 to 30 minutes at a time. The resident was only allowed to leave the property for 15 minutes at 7:30 p.m. because the doors to the home would be locked at 8:00 p.m.

Resident #011 was not happy with this schedule because they could not go out for specified reasons as they pleased. They felt their dignity and choice in relation to leaving the home's property for specified reasons was not respected.

The Administrator stated the resident could go out for specified reasons whenever they wanted regardless of the schedule.

Staff failing to collaborate with each other when developing and implementing resident #011's plan of care in relation to leaving the home's property for specified reasons, resulted in the resident being unable to leave the property for specified reasons when they desired.

Sources: resident #011's progress notes, smoking assessment, Complaint Log #006920-21, observations of resident #011, and interviews with BSO RN #108, DOC #101, Social Worker #107, and resident #011. [s. 6. (4) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 132.1 Recreational cannabis

Specifically failed to comply with the following:

(1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada). O. Reg. 440/18, s. 2.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure they had a written policy or procedure, with respect to residents, related to the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

A complaint was received by the Director related to recreational cannabis being removed from a resident's room and discarded.

A Cannabis product containing tetrahydrocannabinol (THC) and cannabidiol (CBD) was found in a resident's room. The drug was confiscated by a registered staff and discarded.

The resident said that staff went through their drawers and cupboards and took their cannabis oil away from them. They were upset by this because the cannabis oil cost them a lot of money and they felt their privacy was breached.

DOC #101 said that there was no physician order for the cannabis oil because it was recreational and therefore the resident could not use it.

DOC #101 said the home would refer to their Medical Cannabis policy, revised June 1, 2019, when concerns arose related to recreational cannabis for residents. This policy did not include information on the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis for residents.

Failing to have a policy or procedure related to residents and recreational cannabis, may have contributed to a resident's recreational cannabis oil being removed from their room and discarded. It may also have contributed to them feeling as though their privacy was breached.

Sources: resident's progress notes, Complaint intake, the home's policy Medical Cannabis, observations of residents, and interviews with DOC #101, and a resident. [s. 132.1 (1)]

Issued on this 11st day of August, 2021 (A1)

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

Original report signed by the inspector.