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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Amended Public Report (A1)

Report Issue Date January 19, 2023

Inspection Number 2022-1094-0002

Inspection Type

☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up

☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy

☐ Other _____

Licensee

Lutheran Homes Kitchener-Waterloo

Long-Term Care Home and City

Trinity Village Care Centre, Kitchener

Lead Inspector

Nuzhat Uddin (532)

Inspector who Amended Digital Signature

Nuzhat Uddin Digitally signed by Nuzhat Uddin
Date: 2023.02.02 15:54:11 -05'00'

Additional Inspector(s)

Craig Michie (000690) was present during this inspection.

April Racpan (218)

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect Administrative Monetary Penalties (AMP). The Complaint, Critical Incident System, Follow-Up inspection, inspection #2022-1094-0002 was completed on December 13, 2022.

INSPECTION SUMMARY

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Central West District
609 Kumpf Drive, Suite 105
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The Inspection occurred on the following date(s):
December 13- 22, 2022.

The following intake(s) were inspected:

- Intake: #00002348 was related to allegations of improper care.
- Intake: #00011046 was related to no primary physician.
- Intake: #00011711 was related to a follow up to a compliance order (CO), Inspection #2022_094_0001, Compliance Order (CO) #001, s. 140 (2) of O. Reg. 246/22, Compliance Due Date (CDD) November 4, 2022.
- Intake: #00012020 was related to staff to resident abuse.

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

Medication Management
Reporting and Complaints
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out the Minister's Directive that applies to long-term care homes (LTCH).

The Minister's Directive: COVID-19 Response Measures for LTCHs effective August 30, 2022, section 1.4 states that licensees are required to ensure that enhanced environmental cleaning and disinfection for high and frequently touched surfaces is performed once per day and more frequently in outbreak areas.

Examples of high touched surfaces include but are not limited to: call bells, bed rails, light switches, and toilet handles that could be found inside resident rooms.

As per the LTCH's Housekeeping (Procedures) Resident Room Cleaning Policy #1.02, section 3.4 stated

that during an outbreak, resident rooms were to be cleaned on a daily basis, ensuring that the non-isolated rooms were cleaned first. Housekeeping staff were to follow a checklist that included a list of the required high-touch areas to be cleaned while the home was in an outbreak.

The LTCH was declared to be in a COVID-19 outbreak on December 9, 2022. By December 14, 2022 and three out of five resident home areas (RHA) were in a COVID-19 outbreak.

The designated housekeepers that worked on the RHAs stated that they only cleaned the high touched areas of five different resident bedrooms per day. They said the remaining resident rooms received a "spot check" cleaning such as the removal of garbage per day. They said they were not provided with any directions related to the enhanced frequency of cleaning high touched areas while the home was in an outbreak.

The home's Facilities Manager and IPAC Managers clarified that there was a designated staff member that provided additional cleaning and disinfection of high touched surfaces during the evenings throughout the home, including the RHAs in outbreak. However, their tasks did not include cleaning and disinfection of high touched surfaces in resident rooms.

The IPAC Managers stated that they did not have a procedure in place to ensure that high touched areas were cleaned frequently in outbreak areas for the period while the home was in an outbreak.

Not ensuring that enhanced measures for the frequency of cleaning and disinfecting high touch surfaces in outbreak areas was carried out as per the Minister's Directive, placed a moderate transmission risk to residents while the home was in a COVID-19 outbreak.

Sources: Minister's Directive: COVID-19 Response Measures for LTCHs (dated August 30, 2022), Public Health Ontario (PHO) Key Elements of Environmental Cleaning in Healthcare Settings (dated July 16, 2021), LTCH's Housekeeping Procedures) Resident Room Cleaning Policy #1.02 (reviewed January 2022), LTCH's Housekeeping Work Routine Tasks and Resident Room Cleaning Checklist, interviews with housekeepers, Facilities Manager, and IPAC Managers.
[218]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed in as much detail as possible, when there was an incident of a COVID-19 outbreak at the long-term care home (LTCH).

The LTCH went into a confirmed COVID-19 outbreak declared by Public Health (PH) on December 9, 2022, that started with two positive resident cases on the resident home area (RHA). By December 14, 2022, another two RHAs were also declared in a COVID-19 outbreak due to additional resident cases.

A Critical Incident Report was not submitted to the Director until ten days later on December 19, 2022. By this time, there had already been an identified spread of multiple resident cases throughout three RHAs.

Failure to report disease outbreaks immediately to the Director placed residents at potential risk because it could have delayed actions in responding to disease outbreak measures.

Sources: Critical Incident (CI) report, PH outbreak declaration letter dated December 9, 2022, interviews with the IPAC Manager and PH Manager.
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WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

An RPN assessed a resident three times due to the resident experiencing a decline in health status. An RN also assessed the resident when they became aware of the resident's change in condition. Both the RPN and RN did not document their assessments and reassessments.

When the RPN and the RN did not take immediate actions to document their assessment, reassessment and the resident's responses, it placed the resident at moderate risk of harm when they experienced a progressive health decline.

Sources: CIS, record review, investigation notes, e-mail from EMS, interview with staff and ADOC.

[532]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall:

a) Ensure that an identified Personal Support Worker (PSW) receives training on the different types of abuse, and actions that could cause abuse or neglect. The education should also include training related to the Gentle Persuasive Approach (GPA).
b) Ensure that an RN receives training on what actions to take when responding to a resident experiencing a rapid decline in health condition.
c) Document the education, as outlined in a) and b), including the date, format, staff attending the training, including the staff member who provided the education.

Grounds
The Licensee has failed to ensure that an identified resident was protected from physical abuse by a staff and that another identified resident was protected from neglect by a staff member.

For the purpose of this Act and Regulation, “physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain.”

For the purpose of this Act and Regulation, “neglect means 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.”

A) A staff member was witnessed using force on a resident during care. The resident sustained injuries related to the incident.

The home’s investigation notes, and an interview conducted with the Assistant Director of Care (ADOC)

indicated that a staff member used physical force on a resident during care. Following the incident, the staff member acknowledged that their actions were inappropriate for the situation.

Failure to protect the resident from physical abuse by a staff member resulted in resident sustaining injuries and placed them at actual risk of harm.

B) A critical incident report documented a complaint received by the home related to a significant delay in calling the paramedic services and transferring a resident to the hospital.

It was noted that there was a decline in a resident's health status.

An RN assessed the resident but did not document their assessment findings, did not notify the resident's substitute decision maker (SDM) or the physician immediately and did not read the emergency care plan correctly. The RN recognized their inaction in responding to the resident's health care needs.

The ADOC said that the delay in calling the ambulance, assessments not being documented by RN and late notification to the SDM and physician, were considered to be neglectful actions in responding to the resident care needs.

The RN's inaction placed the resident at actual risk of harm when they experienced a progressive health decline.

Sources: CIS, record review, investigation notes, e-mail from EMS, interview with staff.

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This order must be complied with by February 28, 2023.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #002 of inspection #2021_796754_0018, LTCA, 2007 s. 19 (1)

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and

(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.