Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 19, 2023	
Inspection Number: 2023-1094-0006	
Inspection Type: Follow up Critical Incident System	
Licensee: Lutheran Homes Kitchener-Waterloo	
Long Term Care Home and City: Trinity Village Care Centre, Kitchener	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature**
Additional Inspector(s) Nuzhat Uddin (532)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 5, 6, 7, 11, 2023
The inspection occurred offsite on the following date(s): July 10, 2023

The following CI intake(s) were inspected:

- Intake: #00088552 - Alleged Staff to Resident Neglect
- Intake: #00090059 - Resident fall resulting in change to resident status.
- Intake: #00090485 - Alleged Staff to Resident Neglect.

The following follow-up intake(s) were inspected:

- Intake: #00085256 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 1.
- Intake: #00085257 - Follow-up #: 1 - O. Reg. 246/22 - s. 61 (4) (a)
- Intake: #00088680 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 4.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1094-0003 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Nuzhat Uddin (532)

Order #002 from Inspection #2023-1094-0003 related to O. Reg. 246/22, s. 61 (4) (a) inspected by Nuzhat Uddin (532)

Order #001 from Inspection #2023-1094-0005 related to O. Reg. 246/22, s. 53 (1) 4. inspected by Nuzhat Uddin (532)

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Palliative Care
- Pain Management
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident’s plan of care was provided to the resident as specified in the plan.

Rationale and Summary:

A resident was left in bed for two days, when staff members misinterpreted an update made by a team member regarding the resident's transfer status.

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A staff member said the resident's plan of care was not followed and stated the resident was at high risk being left in bed for two days. They noted that there was negative impact to the resident as a result of the incident.

Failing to ensure that the resident's plan of care was followed placed the resident at high risk for potential altered skin integrity and other complications.

Sources:
Interview with a staff member, clinical records for the resident, CIS #2580-000050-23

[000685]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from neglect by a Personal Support Worker (PSW).

"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. O. Reg. 246/22 s. 7.

Rationale and Summary:

The resident was left in their room for over five hours without care.

A staff member said that they found the resident asleep in their assistive device in their room and were in need of personal care.

The Director of Care (DOC) stated that the home's investigation determined it was staff to resident neglect.

This incident of neglect posed moderate risk to the resident as it put them at risk of potential skin breakdown, pain, and falls.

Sources:
Interview with staff members, Interview with DOC, home's investigative notes, CIS #2580-000039-23

[000685]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an allegation of neglect related to a resident was reported to the Director immediately.

Pursuant to s. 154 (3) of the FLTCA, 2021, the licensee is vicariously liable for staff members failing to comply with subsection 28 (1) 2.

Rationale and Summary:

Night shift staff discovered that the resident had not received assistance with evening care.

A staff member stated they informed another staff member of the alleged neglect and that staff member stated they did not report it to anyone.

The DOC said they did not become aware of the incident until three days later. The DOC stated that this incident should have been reported immediately by the staff member and the on-call manager should have been notified.

The home's failure to report to the Director immediately after becoming aware of an allegation of neglect of the resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources:
CIS 2580-000039-23, interview with staff members, interview with DOC.

[000685]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.

The licensee has failed to ensure that when making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the outcome or current status of the individual or individuals who were involved in the incident.

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Rationale and Summary:

An amendment was requested for a Critical Incident (CIS) by the triage inspector (TI) for an update on the progress and outcome of the home's investigation.

The CIS did not include the resident's status, nor the outcome or current status of the individual who was involved in the incident.

Two days later, the home submitted an amendment which stated, "pending investigation". No further amendments were sent to the Director thereafter.

The DOC stated they did not get a chance to update the CIS.

The home's failure to include the outcome of the investigation may have delayed the Director's ability to respond to the incident in a timely manner.

Sources:
Interview with DOC, CIS 2580-000039-23

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