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

Original Public Report

Report Issue Date: December 8, 2023
Inspection Number: 2023-1094-0008
Inspection Type:
Critical Incident

Licensee: Lutheran Homes Kitchener-Waterloo
Long Term Care Home and City: Trinity Village Care Centre, Kitchener

Lead Inspector	**Inspector Digital Signature**
Yami Salam (000688)	Yami Salam Digitally signed by Yami Salam Date: 2023.12.12 15:00:30 -05'00'

Additional Inspector(s)
Alicia Campbell (741126)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 28 - 30, 2023 and December 1, 5 - 6, 2023.

The following intake(s) were inspected:
- Intake: #00093337 - CI# 2580-000054-23 Related to falls prevention and management.
- Intake: #00097391 - CI# 2580-000063-23 Related to medication administration
- Intake: #00097807 - CI #2580-000066-23- Related to resident-to-resident physical abuse and responsive behaviour

The following intakes were completed in this inspection:

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· Intake: #00100538 - CI# 2580-000073-23 Related to falls prevention and management

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse.

As per O. Reg. 246/22 s. 2 (1), "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")

Rationale and Summary:
A resident sustained an injury after they were hit by another resident.

A staff member stated that after the altercation, the resident was shaking and upset.

Sources: Resident's medical records; interviews with Manager of Cognitive Care, DoRC and other staff; review of the home's investigation notes. [741126]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours.

Rationale and Summary:
A resident had an intervention for the management of their responsive behaviours.

On a specific date, the intervention was not followed by staff, and the resident had a physical responsive behaviour causing an injury to another resident.

The Manager of Cognitive Care stated that the resident should have had their intervention for the management of responsive behaviours in place at the time of the incident.

Failure to ensure that the resident's intervention for responsive behaviours was implemented resulted in injury to another resident.

Sources: Residents' clinical records; interviews with Manager of Cognitive Care, DoRC and other staff; review of the home's investigation notes. [741126]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that two residents were administered a medication in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
Two residents received new medication orders, but the orders were not transcribed and administered to the residents for an extended period of time.

Assistant Director of Care (ADoRC) stated that the residents did not receive the medications as prescribed.

Residents were at risk of harm when the staff did not administer the prescribed medications ordered for the residents.

Sources: Residents' medical records, review of medication incident reports, home's Physician's Orders/Changes/eMAR-eTAR Processing Policy (Last reviewed September 2023), Quarterly Med Review Policy (Last reviewed September 2023), interview with RN #105, ADoRC and other staff. [000688]