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

Original Public Report

Report Issue Date: August 16, 2024
Inspection Number: 2024-1094-0002
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**
Diane Schilling (000736)	Diane Schilling Digitally signed by Diane Schilling Date: 2024.09.06 11:56:09 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7 & 12-15, 2024
The inspection occurred offsite on the following date(s): August 8, 2024
The following intake(s) were inspected:

- Intake: #00111852 related to fall prevention and management
- Intake: #00115929 - related to an outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The home has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary
A resident had several falls. An x-ray revealed a diagnosis of a fracture.

No post fall assessment was completed for one of the falls. The Director of Care (DOC) stated that the clinically appropriate post-fall assessment was to be completed in the assessment tab of Point Click Care (PCC) and this was not done.

Failure to complete a post-fall assessment put the resident at risk of not having a comprehensive assessment completed to identify the contributing factors that led to the fall.

Sources: The home's fall policy, interview with the Director of Care and others, the resident's clinical records.