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
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Original Public Report

Report Issue Date: October 25, 2024
Inspection Number: 2024-1094-0003
Inspection Type: Critical Incident
Licensee: Lutheran Homes Kitchener-Waterloo
Long Term Care Home and City: Trinity Village Care Centre, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 17, 18, 22, 23, 2024

The following intakes were inspected:

- Intake: #00111841 related to resident fall resulting in injury
- Intake: #00122984 related to neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was provided assistance as per their plan of care related to bathing.

Rationale and Summary
A resident had scheduled showers on Monday evenings and Friday mornings.

Interviews with the resident indicated that the resident was scheduled for a shower however, they did not receive one.

The Director of Care (DOC) acknowledged that staff did not shower the resident as per their care plan, nor did staff attempt to reschedule the shower for a later day.

When the home failed to implement the interventions specified in the resident's plan of care, it negatively impacted the resident's well-being.

Sources: Review of resident records, interviews with the resident and DOC

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that the planned care for a resident was set out to include a fall intervention.

Rationale and Summary
In January and February of 2024, progress notes indicated that a resident had a fall intervention in place.

Upon review of the resident's records, the intervention was not included in their written plan of care until March of 2024.

The DOC acknowledged that the resident's written plan of care should have included the fall intervention when it was initially implemented.

By not ensuring that the intervention was set out in the resident's written plan of care, staff may not have known to apply the intervention.

Sources: Review of resident records, interview with the DOC.

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.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the home immediately reported an allegation of neglect to the Director.

Rationale and Summary
According to FLTCA s. 154 (3), the licensee is vicariously liable when a staff member failed to comply with subsection 28 (1).

A resident informed staff that they did not receive evening care on two evenings, and did not receive their scheduled bath on the day prior. Staff did not inform anyone until the next evening.

The DOC acknowledged that the home's management team was not made aware of the allegation immediately and as a result, it was not reported to the Director in a timely manner.

By failing to report an allegation of neglect, the Director was unable to respond to the incident in a timely manner.

Sources: Incident report, interviews with staff and the DOC

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure that a resident was provided assistance as per their plan of care related to continence care.

Rationale and Summary
A resident required staff to change their incontinent product upon rising, after meals, prior to bedtime, and through the night as required.

During an interview, the resident stated that they did not receive their required continence care.

The DOC verified that staff was assigned to care for the resident during an evening shift, and acknowledged that staff did not provide care as per the resident's care plan.

By failing to implement the interventions specified in the resident's plan of care, it increased the risk of infection and negatively impacted the resident's well-being.

Sources: Review of resident records, interviews with the resident and DOC