

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

Public Report

Report Issue Date: February 14, 2025

Inspection Number: 2025-1094-0001

Inspection Type:

Complaint
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 date(s): February 5, 6, 7, 11, 12, 14, 2025

The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake: #00131341 - A complaint related to resident care.
- Intake: #00133901- Related to Alleged abuse of a resident.
- Intake: #00137179 - Related to an unwitnessed fall.
- Intake: #00137776 - A complaint related to resident care and wound care.
- Intake: #00137784 - Related to alleged improper care.

The following intakes were bundled:

- Intake: #00134968 - Related to an unwitnessed fall.
- Intake: #00135444 - Related to an unwitnessed fall.

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

Skin and Wound Prevention and Management
Resident Care and Support Services

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure a resident was treated with courtesy and respect during morning cares.

Sources: Critical Incident Report, interview with a resident.
[000736]

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) (c)

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

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear direction to staff related to offloading techniques while the resident was in a wheel chair.

Sources: Observation, medical record review of a resident, interview with staff.

[000688]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure the care set out in the plan of care was provided to the resident. On multiple occasions, a resident did not have their fall interventions applied.

Sources: Resident clinical record, review of pictures, interview with staff.

[000736]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

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

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The Licensee failed to comply with the home's Falls Policy when they did not complete the Head Injury Routine when a resident had an unwitnessed fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program are complied with. Specifically, the home's falls policy directed that if a resident had an un-witnessed fall a Head Injury Routine would be implemented.

Sources: Head Injury Trend Report, Home's Falls Policy, Interview with staff.
[000686]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The Licensee failed to comply with the home's Pain Management Policy when they did not complete the pain assessment.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Pain Management program are complied with. Specifically, the home's Pain Management policy directed that pain assessments be

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

completed on readmission and with significant changes using a clinically appropriate pain assessment tool

Sources: Resident's clinical record, Pain Management Policy and Interview with staff. [000686]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a weekly skin assessment for a pressure injury between January 2025 and February 2025.

Sources: Observations, resident medical record review, interview with staff.

[000688]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

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

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to ensure that a response, acknowledging the receipt of a complaint for a resident, was provided with a date that they could expect a resolution as the home was not able to complete the investigation within 10 business days.

Source: Critical Incident Report, interview with staff.

[000688]