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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 11, 2025
Original Report Issue Date: January 20, 2025
Inspection Number: 2024-1094-0004 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Lutheran Homes Kitchener-Waterloo
Long Term Care Home and City: Trinity Village Care Centre, Kitchener

AMENDED INSPECTION SUMMARY

This report has been amended to:
Amendments made include: NC#008 regarding the resident number.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5-6, 9-10, 12-13, 17-20, 23, 2024

The following intake(s) were inspected:

- Intake: #00126722 - Complainant concerns regarding care of resident.
- Intake: #00127076 - 2580-000069-24 - Improper care of resident resulting in an injury.
- Intake: #00129481 - 2580-000074-24 - ARI-COVID Outbreak on area.
- Intake: #00130431 - 2580-000078-24 - Neglect to Resident by staff regarding continence care.

- Intake: #00130821 - 2580-000080-24 - ARI-COVID Outbreak on area.
- Intake: #00131196 - 2580-000081-24 - Staff to resident physical abuse.
- Intake: #00131341 - Complainant concerns regarding care of resident.
- Intake: #00131657 - 2580-000082-24 - Staff to resident verbal and physical abuse.
- Intake: #00131883 - 2580-000083-24 - Unwitnessed fall of resident resulting in injury.
- Intake: #00133741 - 2580-000088-24 - Alleged neglect of resident by staff.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Palliative Care
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee as failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, written policies and procedures for cleaning and disinfection of client/patient/resident areas and equipment that include: Procedures for routine (e.g daily) cleaning and disinfection.

The home failed to ensure that there were policies procedures in place whereby staff are cleaning and disinfecting high touch surfaces, using at a minimum a low-level disinfectant, at least daily.

Rationale and Summary

The Environmental Services Manager identified that the home's policy for cleaning and disinfecting resident rooms did not state how often high-touch surfaces were to be cleaned within resident rooms.

When the LTCH failed to have a policy that dictated the procedure for disinfecting high-touch surfaces in resident rooms, there was risk of infection for the residents.

The policy was updated to specify that high-touch surfaces were to be cleaned, daily, in resident rooms.

Sources: Interview with Environmental Services Manager, Environmental Services Manual, and PHO: Best Practices for Environmental Cleaning and Prevention and Control of Infections in All health Care Settings, 3rd Edition, April 2018.

Date Remedy Implemented: December 19, 2024.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 has failed to ensure that the care set out in the resident plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A complaint was submitted to the Director regarding concerns about the home's failure to implement the resident's falls interventions. Photos were shared by the complainant, which showed the resident in bed, with the falls mats against the wall.

The resident's care plan stated that the floor mat is to be placed on both sides of bed while the resident is in bed. Interview confirmed the care plan, that the mats were not on the floor while the resident was in bed, in the photo, and that this was not compliant with the resident's care plan.

Failure to ensure that the resident's plan of care was followed placed the resident at moderate risk for falls.

Sources: Photos provided by the complainant, resident's care plan, and interviews with two staff.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in resident's plan of care was documented.

Rationale and Summary

The Point of Care (PCC) documentation for the month of November 2024 shows 38 of 60 of the resident's opportunities for snacks were documented as "not applicable" (NA).

A staff stated that the resident was sleeping during the morning snacks where the staff documented in PCC that the resident's snack intake was "NA".

The Director of Care (DOC) stated there were better options available for documenting snacks.

When staff failed to document the resident's snack intake, the resident was at nutritional risk.

Sources: Interview with staff, resident's documentation survey, and "Charting for POC" Policy.

WRITTEN NOTIFICATION: Duty to Protect

NC #004 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 failed to protect a resident from physical abuse by a staff.

For the purpose of the Act and this regulation, “physical abuse” is the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

While providing care to the resident, the staff slapped the resident on their body with an open hand. The staff, who witnessed the incident, stated that the action met the definition of physical abuse. Following an internal investigation, DOC said that the incident was regarded as physical abuse by the home.

Failing to protect the resident from physical abuse by staff member could have resulted in potential harm to the resident.

Sources: Critical Incident System report 2580-000082-24, the home's investigation notes, interviews with the staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with for resident #001. Specifically, the home's "Resident Abuse/Neglect" policy directed staff to immediately report any alleged, witnessed, or

suspected abuse to the on-call manager.

Rationale & Summary

In November 2024, a staff was made aware of an allegation of abuse of a resident and they did not report it to the on-call manger immediately. Instead, the staff sent an email which was not viewed by management until the following day.

The DOC confirmed that the staff should have followed the home's abuse policy and called the on-call manager that day. They also stated that if management had been notified the same night of the allegation, the staff would have been sent home immediately pending investigation, as per the home's policy requirement.

When the staff failed to follow the home's abuse policy, management was not made aware of the abuse allegation immediately and there was risk to the resident as the staff continued providing care to them for the remainder of their shift.

Sources: Clinical record review for the resident, the home's "Resident Abuse/Neglect" policy, PM A1.10, revised January 2024, and interview with the DOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee failed to ensure that when a resident's family reported an allegation of abuse of the resident, appropriate action was taken by staff in response to the incident.

Rationale & Summary

A family member of the resident reported observing a staff perform rough care on the resident in November, 2024 to another staff who then reported to a third staff. The family member reported bruising of unknown origin to the resident's arms.

There were no assessments documented for the resident on the date of the incident, related to this circumstance.

The DOC stated that a resident should be assessed by a registered staff immediately after an allegation of abuse.

When registered staff members did not assess the resident at the time the incident was reported, there was risk that the resident had pain or injury that was unaddressed by the staff.

Sources: Clinical record for the resident, interview with the resident's family and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 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.

A) The licensee has failed to ensure that the home immediately reported the 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) 2.

On an unknown day in May 2024, a staff observed another staff slap a resident on their body with an open hand. According to the DOC, the staff failed to report the incident as required, and management was not informed until November 2024, when it was reported to the after-hours line.

When the licensee failed to ensure that all staff immediately reported any allegation of abuse, it prevented the home from investigating the incident immediately and responding accordingly.

Sources: Critical Incident System report 2580-000082-24, interviews with staff and DOC.

B) The licensee has failed to ensure that an allegation of abuse for resident was reported to the Director immediately.

Rationale & Summary

A family member of a resident reported observing a perform rough care on the resident in November 2024, to another staff. The staff then notified another staff, who emailed the manager on-call of this allegation. The manager-on-call did not see this email until the following day.

The DOC stated that staff performing rough care on a resident would be considered abuse, whether it was alleged, suspected or witnessed and the Director should have been notified of the allegation in November 2024.

Failing to report this allegation of staff to resident abuse to the Director immediately may

have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical Incident #2580-000081-24 and interview with the DOC.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

The licensee has failed to ensure that the care plan must identify the resident and must include, at a minimum, the following with respect to the resident: Any risks the resident may pose to themselves, including any risk of falling, and interventions to mitigate those risks.

Rationale & Summary

The resident was admitted to the home in November, 2024. The resident's progress note on their date of admission, stated that the resident was at moderate risk of falls and a history of a fall out of bed on one occasion.

In November 2024, the resident self reported their fall and were transferred to hospital and were admitted with a fracture to the left hip.

A staff acknowledged that there were no interventions developed for the resident when they were identified as a fall risk.

24-hour admission care plan did not include risk of falls that the resident posed to themselves, and interventions to mitigate those risks were not developed, which placed the

resident at risk of injuries.

Sources: CIS #2580-000083-24, review of fall risk assessment, 24-hour admission care plan, the resident's progress notes, and interview with staff.

WRITTEN NOTIFICATION: Personal Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The Licensee failed to ensure that the resident's individualized plan of care was followed, specifically related to personal care, including dressing and grooming, daily.

Rationale and Summary

A complaint was submitted to the Director regarding concerns about personal care for the resident. Photos were shared by the complainant, which indicated that this care was not performed on certain dates in November 2024.

The resident's care plan stated that they were to receive daily assistance with grooming and dressing, and required assistance to perform these tasks.

Interview with a staff confirmed that the resident is to be groomed daily, and that the resident did not appear to be groomed in the photo. The staff also confirmed that the resident is to be dressed with their equipment daily, and they was not dressed in the photo.

Failure to provide individualized personal dressing and grooming may affect the resident's comfort, dignity, and wellbeing.

Sources: Complainant photos of the resident, provided by the complainant, the resident's care plan, resident's documentation survey, and interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 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, when the resident demonstrating wandering behaviours, strategies were developed and implemented to respond to these behaviours.

Rationale & Summary

The CIS report stated that the resident was found by a staff on the floor of their unit, near a resident room doorway. The resident sustained a laceration for which they were transferred to the hospital.

The resident's plan of care directed staff to monitor resident closely for safety.

According to the alarm report on the date of the incident, the resident's wander alarm was activated. The staff discovered the resident on the floor of a resident's room while walking by.

The DOC stated that the alarm was not answered for more than 15 minutes.

Failure to respond to strategies and interventions set out in the plan of care impacted the resident and placed them at risk of harm.

Sources: CI #2580-000069-24, "Omni go" policy date of origin March 2022, and date of revision December 2024; plan of care for the resident, investigation notes, interviews with staff and the DOC.

WRITTEN NOTIFICATION: Palliative Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (a)
Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(a) quality of life improvements;

The licensee has failed to ensure that the palliative care options made available to the resident include, at a minimum, quality of life improvements in the form of turning and repositioning during palliation.

Rationale and Summary

The resident's care plan did not include direction for turning and repositioning for their palliative care.

The resident's Palliative Care Record does not have documentation that the resident was turned and repositioned for 7 hours and 45 minutes, consecutively. Other care, such as oral care, is documented during that time. There is not documentation to substantiate that the resident received the care of turning and repositioning during this time.

A staff stated that turning and repositioning is part of palliative care plans, and are important to the prevention of skin break down. The staff stated that turning and repositioning would

occur at least every two (2) hours.

A staff stated that the completion of repositioning by PSWs is documented within the Palliative Care Record.

When the licensee failed to ensure that the palliative care option of turning and repositioning during palliation were completed by the staff, the resident may have experienced increased discomfort.

Sources: Resident's care plan, end of life care orders, and palliative care record, and interviews with staff.

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (b)
Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(b) symptom management;

The licensee has failed to ensure that the Nurse Manager, and subsequently the Resident Care Coordinator (RCC), were informed of concerns related to pain assessments.

In accordance with O. Reg, 246/22 s. 11 (1) b, the licensee is required to make palliative care options made available to the resident, including symptom management.

Specifically, the licensee did not comply with the home's policy titled "Pain Management: Pain and Palliative Committee", which stated to that, upon the completion of any and all completed Pain Assessments, the Nurse Manager will be immediately notified if there are

identified concerns and referral to RCC on PCC.

Rationale and Sources

The resident received a PRN for pain during their end of life care. The staff recorded the intervention as ineffective within the resident's eMAR. There were no progress notes to indicate that the staff communicated this concern to the Nurse Manager. An interview with the staff confirmed that it was not communicated to the Nurse Manager.

The home's policy, "Pain Management" states that upon the completion of any and all completed Pain Assessments, the Nurse Manager will be immediately notified if there are identified concerns and referral to RCC on PCC.

By failing to follow the home's policy, appropriate interventions were not taken to provide for the resident's symptom management.

Sources: The resident progress notes and eMAR, "Pain Management" policy, interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with the IPAC Standard, revises September 2023, section 5.6, the licensee shall ensure that surfaces are cleaned at the required frequency.

Specifically, the licensee has failed to ensure that the high-touch surfaces in resident rooms are cleaned and disinfected, daily.

Rationale and Summary

The Inspector observed that a staff did not clean the following high-touch surfaces within a resident room: bedrails, call bell, and end tables. The staff stated that those surfaces are cleaned once weekly during the room's "deep clean", and if they are visibly soiled.

Failure to clean high-touch surfaces in resident rooms, daily, may increase the risk of infection transmission.

Sources: Observation in December 2024 and interview with the staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure a resident's substitute decision-maker (SDM) was notified of the results of the home's investigation immediately upon completion of the investigation.

Rationale & Summary

A family member of a resident reported observing a staff perform rough care on the resident in November 2024, verbally to the nursing staff, and through email correspondence to DOC. The DOC received this correspondence the following day and

responded to the family member, stating that they would be investigating and would contact them with updates.

The resident's family member stated that besides this initial response from the DOC, they have not been contacted since.

The DOC confirmed they have not followed up further with the resident's family member, nor did they notify them of the results of the investigation.

By failing to update the resident's family member with the home's internal investigation results, they were not provided any reassurance that this incident had been addressed, nor that the staff would in fact no longer be caring for the resident as requested by the family member.

Sources: Email communication between the resident family member and the DOC on November, 2024, and interviews with the resident's family member, and the DOC.

WRITTEN NOTIFICATION: Police notification

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of an allegation of staff to resident abuse that the licensee suspected may constitute a criminal offence.

Rationale & Summary

A family member of a resident reported observing a staff performing rough care on the resident in November 2024, to another staff, as well as to the DOC via email correspondence.

The CI submitted to the Director did not indicate that police services had been notified of the allegation.

The DOC stated police should be contacted about an allegation of abuse immediately depending on the nature of the incident, and that an allegation of staff providing rough care to a resident would be considered abuse. They confirmed that police were not notified about this allegation until two days later. They also stated that given the nature of what was reported by the resident's family member, they felt it should be reported to police.

By failing to notify the police services immediately, the police were not given the opportunity to begin their investigation immediately following the incident.

Sources: CI #2580-000081-24, and interview with the DOC.

WRITTEN NOTIFICATION: Additional requirements, s. 26 of the Act

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee has failed to ensure that a complaint that alleged harm or risk of harm of to a resident was immediately forwarded to the Director.

Rationale & Summary

Family member of the resident reported observing a staff perform rough care on the resident in November 2024, to another staff. The resident's family member also reported the allegation directly to the DOC via email correspondence that same day. The DOC received this correspondence the following day but did not forward the complaint to the Director as required.

The DOC stated they submitted the allegation as an abuse Critical Incident (CI) only.

By failing to forward the written complaint that alleged harm or risk of harm to the resident, the Director was not provided all the necessary information related to the incident for review.

Sources: Email communication between the resident's family member and the DOC in November 2024, and interview with the DOC.