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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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: July 31, 2025
Inspection Number: 2025-1094-0006
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 date(s): July 28-31, 2025
The following intake(s) were inspected:

- Intake: #00150141 related to alleged neglect of a resident by staff
- Intake: #00152716 related to a fall resulting in injury to a resident

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

Prevention of Abuse and Neglect
Reporting and Complaints
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 failed to ensure that a resident was protected from neglect by staff when the resident called for assistance with cares, and a staff member responded but did not return to assist the resident. At the time of inspection, compliance concerns were identified with the assistance for care required by a resident, and due to this the resident experienced negative effects for a period of time.

Sources: Critical incident report, resident records, interviews with resident and staff

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that an incident that resulted in a significant change to

a resident's health condition was reported no later than one business day after the occurrence of the incident.

Sources: Critical incident report, resident records, interviews with staff