



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Jan 21, 2014, 2014_259520_0004, L-000982-13, Critical Incident System

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7

Long-Term Care Home/Foyer de soins de longue durée

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SALLY ASHBY (520)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 14, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, Assistant Director of Resident Care, 1 staff Programs Services, 1 Registered Practical Nurse, 2 Personal Support Workers.

During the course of the inspection, the inspector(s) observed resident and staff, toured resident home area, reviewed resident's clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:



Falls Prevention
Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

Table with 2 columns: Legend and Legendé. It details non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) and the corresponding findings in French under the LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).



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Findings/Faits saillants :

1. The Licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented as evidenced by:

A) Three Head Injury Routine records had incomplete documentation.

B) Director of Resident Care and Assistant Director of Resident Care confirmed there was missing documentation on the Head Injury Routine forms and that the expectation of the home was to have complete documentation. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**



Findings/Faits saillants :

1. The Licensee has failed to ensure that staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations as evidenced by:

A) Assistant Director of Resident Care provided inspector with a restraint inservice for December 2013 (inspector counted 23 out of 350 staff attended). The Assistant Director of Resident Care confirmed the numbers were really low and was further unable to verify how many actually had the training as the staff member was newly employed at the home.

B) Both Administrator and Director of Resident Care acknowledged verbally during interviews that the training numbers for staff were very low and needed to improve.

C) During interviews the Registered Practical Nurse and Personal Support Worker were unable to recall recent training.

2. The Licensee has failed to ensure training shall be provided to all staff who provide direct care to residents: 1. Falls prevention and management as evidenced by:

A) Director of Resident Care confirmed that training numbers for the home were very low (5%) and that the home was trying to get the training done.

B) Interview with a Registered Practical Nurse who was unsure when training for falls prevention had last occurred.

D) Assistant Director of Resident Care was unable to give accurate numbers as to how many staff had received training.

E) Exit conference with the Administrator who verified that staff training numbers in the home were low. [s. 76. (7) 4.]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff are provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110.
Requirements relating to restraining by a physical device**

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the Licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response is documented as evidenced by:

A) The Assistant Director of Resident Care confirmed there was missing or incomplete documentation on multiple occasions for various types of restraints.

The Assistant Director of Resident Care further confirmed the paper documentation for restraints had been implemented in December 2013 and that staff required more education on the documenting process.

B) Director of Resident Care confirmed that there was missing documentation for restraints for many residents on multiple occasions and that the expectation of the home was to have complete documentation. [s. 110. (7) 6.]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the Licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response is documented, to be implemented voluntarily.

Issued on this 21st day of January, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Sally Ashby