Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2013	2013_226192_0020	L-000871-13	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

DEBORA SAVILLE (192), MELANIE NORTHEY (563)

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): November 14, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurse, Personal Support Workers, and the resident.

During the course of the inspection, the inspector(s) reviewed the medical record, incident reports, the homes investigation notes, policy and procedure, and look back reports related to bowel continence and fluid intake.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that there is a written plan of care for each resident that sets out (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

In 2013 resident #001 was left for an extended period of time in the bathroom. Staff failed to return to remove them from the bathroom before the end of their shift. Staff coming on for the evening shift found the resident in the bathroom. Following this incident interventions in the plan of care were updated to include that the resident would not be toileted.

The plan of care for resident #001 indicated under the goal for toileting that the resident will remain on toilet/commode until elimination is complete.

The goal identified within the plan of care contradicted interventions to not toilet resident #001 but return them to bed for brief changes and peri-care.

Posted sign above resident's toilet, in care plan folder and progress notes dated October 23, 2013 indicated resident is not to be placed on the toilet.

Interview with the Registered Practical Nurse (RPN) confirmed that the goal for toileting was not updated when the intervention was updated. It was also confirmed that this could cause confusion for registered staff and Personal Support Workers since a hard copy of the plan of care is available at the nurses station.

The plan of care available to caregivers for resident #001 was not updated at the time of review to include the goals the care was intended to achieve and therefore failed to provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1)]

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 ensuring that there is a written plan of care for each resident that sets out (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that the long-term care home protected resident #001 from neglect by the licensee or staff.

Previously issued as a Voluntary Plan of Corrective Action (VPC) on August 29, 2012.

In 2013 resident #001 was left unattended in the bathroom suspended from the transfer lift for an identified period of time. They were found by the staff starting the evening shift.

In 2013 resident #001 was transferred by mechanical lift to the bathroom where they were positioned over the toilet while suspended in the lift. The resident was checked and then left suspended in the lift for an additional period of time, until found by the staff working the next shift.

Resident #001 was observed to have discolored extremities as a result of holding onto the straps of the lift they were suspended in for over 90 minutes. The resident also sustained redness on their bottom from sitting over the toilet for this extended period of time. It is noted that the bluish tinge of the residents upper extremities returned to normal colour within a short period of time and the redness on the buttock resolved without trauma to the skin.

Review of the home's investigation notes confirms that the incident described above did occur and that the staff member responsible for resident #001 failed to check on the resident, or communicate that they had left the resident in the bathroom prior to leaving for the day.

Interview with staff on the home area confirm that the incident involving resident #001 in 2013 did occur and that as a result of this incident the plan of care for the resident was revised.

The licensee failed to ensure that resident #001 was protected from neglect. [s. 19. (1)]

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 ensuring that residents are protected from abuse by anyone and ensuring that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of the investigation related to the October 2013 incident involving resident #001 and reported in October 2013 in a specified Critical Incident Report.

The Administrator confirmed that results of the neglect investigation were not reported to the Director related to the Critical Incident Report submitted in October 2013. [s. 23. (2)]

Issued on this 15th day of November, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Debora Saville (192) Melanie Northey (563)