Ontario

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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2015	2015_263524_0039	022541-15	Resident Quality Inspection

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

INA REYNOLDS (524), CHRISTINE MCCARTHY (588), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 7, 8, 9, 10, 11, 15, 16, 2015.

The following Critical Incident and Follow-up inspections were conducted concurrently during the inspection:
Log # 027140-15 / CI 2580-000027
Log # 034169-15 / CI 2580-000028
Log # 008402-15

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Resident Care, the Nutrition Manager, the Environmental Services Manager, the Resident Assessment Instrument Coordinator, the Registered Dietitian, one House Manager, 10 Registered Practical Nurses, 10 Personal Support Workers, one Food Service Worker, three Family Members and 41 Residents.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal and snack service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2014_259520_0038	524

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 3. Every resident had the right not to be neglected by the licensee or staff.

Review of two critical incidents submitted by the home revealed that an identified resident was left unattended, sitting on a personal assistive device for a lengthy period of time on two occasions. A previous incident had occurred whereby the resident was also left on the personal assistive device for a lengthy period of time which resulted in an injury.

Record review of the most recent plan of care on PointClickCare for the resident revealed the resident was dependent on staff for personal care needs.

Review of the progress notes and investigation notes revealed the following:
On two different occasions, a personal support worker had placed the resident on a personal assistive device and failed to verbally report to the next shift that the resident had been placed on the device, or document it on the resident daily report sheet or the personal support worker shift report sheet at the end of the shift. A personal support worker went in to the resident’s room at a later time and found the resident was still on the personal assistive device left by the prior shift.

Review of the progress notes revealed the resident sustained physical markings as a result of being left on a personal assistive device for a lengthy period of time.

Interview with the Director of Resident Care on a specified date, confirmed that it was the home's expectation that a personal support worker would verbally inform the next shift and document that a resident was left on a personal assistive device near the end of their shift. In addition, the Director of Resident Care confirmed that the resident was neglected when left on the personal assistive device for a lengthy period of time by a personal support worker resulting in physical markings. [s. 3. (1) 3.]

2. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation of the medication cart in a resident care area on a specified date and time, revealed an unattended medication cart and the computer screen unlocked with resident personal health information accessible.

Interview on a specified date, with a registered staff and the Director of Resident Care confirmed that it was the home's expectation that every resident had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential. [s. 3. (1) 11. iv.]

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 the following rights of residents are fully respected and promoted: 3. Every resident has the right not to be neglected by the licensee or staff; 11. Every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the plan of care on PointClickCare for an identified resident, directed registered staff to provide a supplement three times a day after meals to promote weight gain. The resident was deemed to be at nutritional risk and had significant unplanned weight loss since admission.

During the medication pass on a specified date, it was observed that the resident was provided with a supplement prior to the noon meal.

A registered staff shared that the resident had demonstrated multiple responsive behaviours and the supplement would best be given with the resident's medication.

Review of the Medication Administration Record for the identified resident for a specified period revealed that the supplement was administered prior to meals on the following occasions:

-Breakfast: 32/37 days (86% of the time)
-Lunch: 22/37 days (59% of the time)
-Dinner: 17/37 days (46% of the time)

The Director of Resident Care confirmed that it was the home's expectations that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of a policy issued by the home on specified date, as a safety measure directed staff to use a timer and set the timer for a specific duration after placing a resident on a personal assistive device. If a resident had not used the call bell for assistance within the time frame, the timer would remind staff to return and reassess the resident. In addition, review of a posted message on the PointClickCare Facility Bulletin Board and a memo issued, directed registered staff to ask the personal support workers prior to leaving their shift if any resident had been left on a personal assistive device and document on the daily shift report sheet.

Review of a critical incident submitted by the home revealed that an identified resident was left unattended, sitting on a personal assistive device for an lengthy period of time on a specified date, resulting in physical markings. Investigation notes revealed a personal support worker had not followed the policy as directed and the registered staff failed to ask the personal support workers and document on the daily shift report sheet.

This was confirmed by the Director of Resident Care on a specified date. The Director of Resident Care further stated that it was the home's expectation that procedures were to be complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included, mouth care in the morning and evening.

Interview with an identified resident, revealed that staff were not assisting with mouth care two times a day.

Record review of the Minimum Data Set quarterly assessment for a specified date, under the oral/dental section revealed, "daily mouth care by resident or staff." Record review of the plan of care revealed that the resident required assistance with mouth care and staff were to assist the resident to complete oral care twice daily at a minimum.

Record review of the Point of Care task list for oral care for a specific period of time, revealed no documented evidence that the resident received oral care two times a day at a minimum.

Interview on a specified date and time with a personal support worker revealed that oral care was not being done for the resident twice per day.

A registered staff confirmed that oral care should have been provided to the resident twice a day. Interview with the Director of Resident Care confirmed that it was the home's expectation that oral care was to be provided to residents at least twice a day at a minimum. [s. 34. (1) (a)]

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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

Observation of the medication cart in a resident care area on specified date and time, revealed that the separate locked area within the medication cart where controlled substances were stored was not locked.

Record review of the home's Remedy's RX, Policy and Procedure Manual for Medication Cart and Cart Maintenance, Policy No. 3.3 revealed that "the Narcotic and controlled drugs must be kept in the lock box in the designated drawer of the medication cart or in a separate, double locked stationary cupboard in the locked med room. The lock box must remain locked at all times within the medication cart."

Staff interview with a registered staff revealed that the separate storage area for controlled substances within the medication cart should have been locked. Interview with the Director of Resident Care confirmed that it was the home's expectation that the controlled substances stored in the locked area within the medication cart be locked. [s. 129. (1) (b)]

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 controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

Observation on a specified date and time revealed an unattended and unlocked medication cart in a resident care area.

Record review of the home's Remedy's RX, Policy and Procedure Manual for Medication Cart and Cart Maintenance, Policy No. 3.3, dated September 2013, revealed that "the medication cart MUST be locked when the medication cart is out of sight of the Registered Staff administering the medications."

Staff interview with a registered staff revealed that the medication cart should have been locked while unattended and out of sight. Interview with the Director of Resident Care confirmed that drugs that were stored in a medication cart should be locked at all times, when not in use. [s. 130. 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 to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

On a specified date and time, the Inspector was unable to activate the call bell in an identified resident's room. A personal support worker tried the call bell and was unable to activate the call bell. A registered staff confirmed all call bells should be working in all resident's rooms.

Record review of the home's call bell audit report, revealed that an audit was completed on a monthly basis by the Maintenance department. The report revealed that the identified room was last audited on December 1, 2015.

Staff interview with the Manager of Environmental Services and the Director of Resident Care confirmed that it was the home's expectation that the communication and response system was functioning at all times. [s. 17. (1) (b)]

Issued on this 18th day of January, 2016

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

Original report signed by the inspector.