Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2017	2017_508137_0016	014539-17	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

MARIAN MACDONALD (137), JANETM EVANS (659), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 17 - 21 and July 24 - 28, 2017

There were two Critical Incident System (CIS) inspections and eight Complaint inspections completed during the Resident Quality Inspection (RQI) as follows:
CIS 2580-000025-16/Log # 034891-16 related to falls prevention
CIS 2580-000001-17/Log # 000154-17 related to resident to resident abuse
IL-44396-LO/Log # 012631-16 related to alleged neglect
IL-48263-LO/Log # 033732-16, IL-50605-LO/Log # 005571-17 & Log # 008666-17,IL-NC-50015/Log # 006450-17 and IL-51041-LO/Log # 010446-17 related to care provision
IL-51394-LO/Log # 012207-17 and Log # 017749-16 related to staffing shortages and use of agency staff

During the course of the inspection, the inspector(s) spoke with Chief Operating Officer, Director of Resident Care, Assistant Director of Resident Care, Program Director, Environmental Services Manager, Registered Dietitian, Human Resources Manager, Volunteer Coordinator, Social Worker, Physician, Physiotherapist, Resident Care Staffing Administrator, Payroll/Benefits Administrator, Human Resources Administrative Assistant, Receptionist, Maintenance Worker, Music Therapy Student, four Registered Nurses, 18 Registered Practical Nurses, 20 Personal Support Workers, three Food Service Workers, eight Family Members and 40 residents.

Inspectors also toured resident home areas, common areas, medication storage areas, observed dining and snack service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and pertinent meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **10 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home had received training before performing their responsibilities as required by this section.

During an interview, a Registered Practical Nurse (RPN) said they were from an agency, it was the first time they were at the home and they were here just to administer medications. When asked if they received orientation, the RPN said no. When asked how they would be able to identify residents, during medication administration, the RPN said by looking at the electronic medication administration record (eMAR) picture or asking a Personal Support Worker (PSW).

During an interview, the Assistant Director of Resident Care (ADORC) was asked what

orientation agency staff received, prior to working on home areas. ADORC said agency staff were to come in an hour or two prior to the start of the shift and the Registered Nurse (RN) would meet them to provide some orientation. A Registered Nurse was in ADORC office and said they did not provide any orientation to the agency RPN.

During an interview, one RPN said they spent approximately 40 minutes with the agency RPN, reviewing Point Click Care (PCC), as well as the medication and treatment carts.

A review of the agency's agreement with the home stated:
“The agency in regular course of fulfilling their agreement The Home/Client warrants the following:
• That all staff assigned to the home have received and understand the Home’s/Client job description (Check list of duties) as delineated by the Home, prior to the start of their shifts at the Home.
• The Home will ensure that all staff assigned to the Home have received and understand the Homes/Client job description (Check list of duties), Health and Safety and Emergency Orientation as delineated by the Home, prior to the start of their shifts at the Home.
• That all registered staff will be oriented for a minimum of four (4) hours or as per the Home’s requirements and billed to the Home.
• The agency will make arrangements with the Home for the orientation requirements. The Agency will provide staff for orientation and training purposes at the regular pay rate quoted”.

During an interview, the DORC said the agency registered staff would not have received four hours of orientation and was unsure of what the home’s requirements were, related to orientation.
Both the DORC and ADORC were not familiar with the check list of duties or with the Health and Safety and Emergency Orientation, as outlined in the agency agreement.
The DORC said some agency staff had received some orientation but there was no documented evidence as to what the orientation included, who provided it, how much orientation was given, there was no orientation checklist and no method in place to track that orientation was completed.

A review of the home’s Time and Attendance Calendar, for January 1 – July 28, 2017, showed that agency staff worked at the home as follows:
RN – 28 shifts; RPN – 111 shifts; PSW – 46 shifts

There was no documented evidence that the agency registered staff received orientation/training, including the home's medication management system, prior to performing their responsibilities in the home. [s. 76. (2)]

2. A review of staff training documentation showed that the home completed training electronically on "My Trainer" prior to working in the home. A list of the training to be completed included Module C07-Resident Abuse. Review of the content of the training did not show documented evidence that the home's policy to promote zero tolerance of abuse and neglect of residents was received in the training.
In interviews Assistant Director of Care, Resident Care Staff Administration and Human Resources Administrative Assistant acknowledged that staff had not received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related non-compliance. [s. 76. (2) 3.]

3. The licensee has failed to ensure that all staff have received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of the home's annual training records showed that there was no documented evidence that the home's policy to promote zero tolerance of abuse and neglect was not contained in the training module.

Assistant Director of Care, Resident Care Staff Administration (RCSA) and Human Resources Administrative Assistant said that the home had not offered annual training related to the home's policy to promote zero tolerance of abuse and neglect.

The severity of this area of non-compliance was determined to be a level one, minimal harm/risk, the scope was a level three, widespread and there was no history of previous related non-compliance. [s. 76. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 staff have receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement, (see definition/description for list of exceptions as stated in section 45 of the regulation).

A review of the home's Time and Attendance Calendar, from January 7 – July 2, 2017, showed there were 28 scheduled shifts where the registered nurse was from an employment agency, including four day shifts, eight evening shifts and 16 night shifts. The registered nurse was not an employee of the licensee and not a member of the regular nursing staff.

The home had a licensed capacity of 150 beds and did not meet the exceptions to the requirement, as stated in section 45 of the regulation.

During an interview, a Receptionist said they were responsible for calling the agency for staffing replacements and the shifts were booked a couple of days in advance of the shift required to be filled.

During an interview, the Director of Resident Care (DORC) said the home had a good complement of registered nurses but they did not always provide their availability so the home utilized an employment agency for registered nurse coverage.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related non-compliance. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the desired bedtime and waking routines for an identified resident were supported and individualized to promote, comfort, rest and sleep.

During an interview, an identified resident said that they felt they had no decision in their bedtime and waking preferences. At times they were either put to bed or awakened earlier than they preferred.
In an interview, the resident stated that they had reported this to the nurse but the outcome was unknown.

A review of the care plan and kardex showed that there were no directions related to the resident's desired bedtime or waking preferences.

During an interview, a Personal Support Worker (PSW) stated that if a resident had a specific time to wake they would find that information in the resident’s kardex but if a residents’ preference fluctuated it would not be in the kardex.
PSW stated that the desired bed time and wake time preferences were not on the kardex for this resident.

A Registered Practical Nurse (RPN) said that the plan of care did not set out specific times for this resident to wake or bed time preference. The RPN stated that when residents requested a change in their preferences, they would notify the nurse manager and the plan of care would be updated to reflect that change.

During an interview, the Assistant Director of Resident Care (ADORC) stated the expectation was that if residents had specific time requests for desired bed time and wake time preferences, they would be placed in the plan of care so that the kardex would reflect those times. ADORC said that, on admission, the identified resident had specific desired preferences for wake times and bed times but the plan of care and kardex did not reflect those preferences.

ADORC stated that they would update the plan of care as the resident's desired preferences for wake times and bed times were not supported and individualized.

The licensee has failed to ensure that the desired bedtime and waking routines for an identified resident were supported and individualized to promote, comfort, rest and sleep.

The severity of this area of non-compliance was determined to be a level one, minimal harm/risk, the scope was a level one, isolated and there was no history of previous related non-compliance. [s. 41.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted prior to hiring a staff member and/or accepted a volunteer who was 18 years of age or older.

A review of three random employee files and a volunteer file showed that there was no documented criminal reference check for a Personal Support Worker (PSW).

Assistant Director of Resident Care (ADORC) and Resident Care Staffing Administrator (RCSA) said that the staff member was currently working at the home.

During interviews, the ADORC, RCSA and Payroll/Benefits Administrator said that there was no criminal reference check for the PSW. ADORC and RCSA said the expectation was that a criminal reference check was to be completed before a staff member started working.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level two, no history of a previous related non-compliance related to this section of the regulations. [s. 75. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint procedures in place incorporate the requirements set out in section 101 for dealing with complaints.

Review of the home's policy Customer Satisfaction Monitoring Concerns and Complaints, last reviewed September, 2012 stated "that residents and their responsible parties are encouraged to make known their problems or complaints and open discussion was encouraged to resolve problems". The policy documented that "all written complaints concerning the care of a resident, the operation of the home or possible harm to a resident, shall immediately be forwarded to the Director with supporting documentation".

There was no documented procedure with respect to how to handle verbal complaints.

A concern process 2016 indicated "that the internal concern process was to discuss the situation with the relevant department managers listed, in person, by phone or email; you should receive a response within 7 days. If you have not received a satisfactory or timely response to the concern they were encouraged to complete the concern form and submit it to the Chief Operating Officer".

In an interview with the Director of Resident Care, they stated that residents and their responsible parties were encouraged to make known their problems and concerns. There would be an open discussion to resolve the problem. The DORC stated they always tried to resolve the problem first, then go to the concern form.

The licensee's written complaint procedure failed to incorporate the requirements set out in section 101 for dealing with verbal complaints.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level three. A Written Notification and a Voluntary Plan of Correction were previously issued during the Resident Quality Inspection (RQI) on December 8, 2014, under Log # L-001608-14 and Inspection # 2014_259520_0038, related to this section of the regulations. [s. 100.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a controlled substance that had been reported missing or unaccounted for was reported to the Director.

Review of a medication incident report showed that during a routine check of the Fentanyl patch on a resident, the Registered Practical Nurse (RPN) noted that the patch was missing.
The report showed that a Personal Support Worker (PSW) had stated that it had come off and the PSW threw it in the garbage. The garbage had been taken to the outdoor garbage container. The report stated that staff members had searched through the garbage container and were unable to locate the patch. Review of an email from the Director of Resident Care (DORC) to the pharmacy and their response was attached to the medication incident report. The email from DORC stated that the home had completed a thorough search of the garbage and that the patch was not found.

In an interview, the DORC stated that they did not complete a Critical Incident System (CIS) report for the missing Fentanyl patch. The DORC stated that the patch was missing but felt it was accounted for, as the PSW knew it had been thrown out.

The licensee has failed to ensure that a controlled substance that had been reported missing or unaccounted for was reported to the Director.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level three. A Written Notification was previously issued during the Resident Quality Inspection (RQI) on November 29, 2016, under Log # 031068-16 and Inspection # 2016_263524_0040, related to this section of the regulations.
. [s. 107. (3) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A Registered Practical Nurse said that the Institute for Safe Medication Practices Canada (ISMP) form titled Medication Safety Self -Assessment for Long Term Care, dated January 27, 2017, was the document used for their annual evaluation. The RPN stated that the Director of Resident Care (DORC), the Assistant Director of Resident Care (ADORC), Pharmacist and a Registered Nurse (RN) were present during the annual review of the medication management system.
The Medical Director, Chief Operating Officer and Registered Dietitian did not participate in the annual evaluation.

During an interview, the Director of Resident Care (DORC) said that the Medical Director, Chief Operating Officer and Registered Dietitian were not present during the annual review completed on January 27, 2017.

The licensee has failed to ensure that the Medical Director, Chief Operating Officer and Registered Dietitian were present during the annual evaluation of the effectiveness of the medication management system in the home.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level two, no history of a previous related non-compliance related to this section of the regulations. [s. 116. (1)]

WN #8: 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 has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The medication cart and medication room observation were completed with a Registered Practical Nurse (RPN) present.
The medication room and the medication cart were locked, however when the medication cart was unlocked, the controlled substances lock box was not locked.

A review of the policy Medication Storage Areas, dated March 1, 2016 stated "Narcotic and controlled medications must be stored in the locked narcotic box within the locked medication cart or in a separate, double locked stationary cupboard in a secure storage area that must be kept locked at all times”.

During an interview, the RPN said that the expectation was that the controlled substance box and the medication cart was to be locked at all times.The RPN stated that when the box was full, it was harder to close but that it was their responsibility to ensure it locked each time.

In an interview, the Director of Resident Care (DORC) stated that it was the expectation that, within the medication cart, the controlled substance box be locked at all times.

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

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level three. A Written Notification and a Voluntary Plan of Correction were previously issued during the Resident Quality Inspection (RQI) on November 29, 2016, under Log # 031068-16 and Inspection # 2016_263524_0040, the RQI on December 4, 2015 under Log # 022541-15 and Inspection # 2015_263524_0039, as well as the RQI on December 8, 2014, under Log # L-001608-14 and Inspection # 2014_259520_0038, related to this section of the regulations. [s. 129. (1) (b)]

WN #9: 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 has failed to ensure that a monthly audit was done of the daily count sheets of controlled substances, to determine if there were any discrepancies.

A review of the medication incident reports showed that in June 2017, there were 10 incidents related to narcotic medication not being given but were signed as given.
A review of a medication incident in May 2017 showed that the narcotic count had been incorrect for five days, as the card had been dispensed with 59 Tylenol #3 and not 60, as recorded on the resident count card.

A review of the medication incident in June 2017, stated that there was one Tylenol #3 missing from the blister pack when it was delivered from pharmacy.

During an interview, the ADORC stated that a monthly review of the narcotic/controlled substance records and resident count cards were not being completed at this time.

Director of Resident Care (DORC) stated that the expectation was the audit of the narcotics, controlled substances and resident count cards be completed monthly and thought the audit was already initiated.

The Clinical Auditor stated that this was an area identified as needing improvement but the audit of the narcotic/controlled substance and resident count cards had not been initiated at this time.

The licensee has failed to ensure that a monthly audit was done of the daily count sheets of controlled substances, to determine if there were any discrepancies.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level three. A Written Notification and a Voluntary Plan of Correction were previously issued during the Resident Quality Inspection (RQI) on December 4, 2015 under Log # 022541-15 and Inspection # 2015_263524_0039, as well as the RQI on December 8, 2014, under Log # L-001608-14 and Inspection # 2014_259520_0038, related to this section of the regulations. [s. 130. 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the Medical Director.

A record review of the monthly medication management committee meeting minutes, from February to June 2017, showed that the medication incidents were reviewed but the Medical Director did not attend these meetings.

A review of the Professional Advisory Committee (PAC) minutes, dated April 19, 2017, stated that monthly medication management committee meetings were being held to review medication incidents. There was no documentation in the minutes that a review of the incidents had been done during this meeting.

During an interview, the Assistance Director of Resident Care (ADORC) stated that they were not reviewed at the PAC meeting. The minutes of the PAC meeting were reviewed with the ADORC and they said that there was no review of medication incidents within the minutes.

During an interview, the Director of Resident Care (DORC) stated that the medication incidents were not reviewed at the PAC meeting, due to the fact that pharmacy had a lengthy review. DORC stated that the incidents were to be reviewed at the monthly medication management committee meeting. DORC acknowledged that the Medical Director does not attend these meetings. DORC stated that the last review of medication incidents with the Medical Director was done in November 2016.

The licensee has failed to ensure that every medication incident involving a resident was reported to the Medical Director.

The severity was determined to be a level one, minimum risk, the scope was level one, isolated, and the compliance history was a level two, no history of a previous related non-compliance related to this section of the regulations. [s. 135. (1)]

Issued on this 30th day of August, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), JANETM EVANS (659), TRACY RICHARDSON (680)
Inspection No. / No de l'inspection :	2017_508137_0016
Log No. / No de registre :	014539-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 23, 2017
Licensee / Titulaire de permis :	LUTHERAN HOMES KITCHENER-WATERLOO 2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7
LTC Home / Foyer de SLD :	TRINITY VILLAGE CARE CENTRE 2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debby Riepert

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To LUTHERAN HOMES KITCHENER-WATERLOO, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must take action to achieve compliance with LTCHA, 2007, S.O. 2007, c.8, s.76(2) to ensure that all staff receive training, prior to performing their responsibilities, as required by this section.

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c. 8, s.76(2).
The plan must:
• identify the timelines for completion of the training
• identify who is responsible for providing the training
• identify the method of which training will be provided
• develop and maintain a written tracking record of completion of the training

Please submit the plan in writing to Marian C. Mac Donald, Ministry of Health and Long-Term Care, Long-Term Care Homes Inspector – Nursing, Long-Term Care Homes Inspection Division, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2 by email, at Marian.C.Macdonald@ontario.ca, by September 1, 2017.

Grounds / Motifs :

1. During an interview, a Registered Practical Nurse (RPN) said they were from an agency, it was the first time they were at the home and they were here just to administer medications. When asked if they received orientation, the RPN said no. When asked how they would be able to identify residents, during medication administration, the RPN said by looking at the electronic medication administration record (eMAR) picture or asking a Personal Support Worker (PSW).

During an interview, the Assistant Director of Resident Care (ADORC) was asked what orientation agency staff received, prior to working on home areas. ADORC said agency staff were to come in an hour or two prior to the start of the shift and the Registered Nurse (RN) would meet them to provide some orientation. A Registered Nurse was in ADORC office and said they did not provide any orientation to the agency RPN.

During an interview, one RPN said they spent approximately 40 minutes with the agency RPN, reviewing Point Click Care (PCC), as well as the medication and treatment carts.

A review of the agency's agreement with the home stated:
“The agency in regular course of fulfilling their agreement The Home/Client

warrants the following:
• That all staff assigned to The Home have received and understand the Home's/Client job description (Check list of duties) as delineated by the Home, prior to the start of their shifts at the Home.
• The Home will ensure that all staff assigned to the Home have received and understand The Homes/Client job description (Check list of duties) Health and Safety and Emergency Orientation as delineated by the Home, prior to the start of their shifts at the Home.
• That all registered staff will be oriented for a minimum of four (4) hours or as per the Home's requirements and billed to the Home.
• The agency will make arrangements with the Home for the orientation requirements. The Agency will provide staff for orientation and training purposes at the regular pay rate quoted".

During an interview, the DORC said the agency registered staff would not have received four hours of orientation and was unsure of what the home's requirements were, related to orientation.
Both the DORC and ADORC were not familiar with the check list of duties or with the Health and Safety and Emergency Orientation, as outlined in the agency agreement.
The DORC said some agency staff had received some orientation but there was no documented evidence as to what the orientation included, who provided it, how much orientation was given, there was no orientation checklist and no method in place to track that orientation was completed.

A review of the home's Time and Attendance Calendar, for January 1 – July 28, 2017, showed that agency staff worked at the home as follows:
RN – 28 shifts; RPN – 111 shifts; PSW – 46 shifts

There was no documented evidence that the agency registered staff received orientation/training, including the home's medication management system, prior to performing their responsibilities in the home.
(137)

2. A review of staff training documentation showed that the home completed training electronically on "My Trainer" prior to working in the home. A list of the training to be completed included Module C07-Resident Abuse. Review of the content of the training did not show documented evidence that the home's policy to promote zero tolerance of abuse and neglect of residents was received in the

training.

In interviews Assistant Director of Care, Resident Care Staff Administration and Human Resources Administrative Assistant acknowledged that staff had not received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related non-compliance.

(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must take action to achieve compliance with LTCHA, 2007, S.O2007, c.8, s.8(3) to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times,

Grounds / Motifs :

1. A review of the home's Time and Attendance Calendar, from January 7 – July 2, 2017, showed there were 28 scheduled shifts where the registered nurse was from an employment agency, including four day shifts, eight evening shifts and 16 night shifts. The registered nurse was not an employee of the licensee and not a member of the regular nursing staff.

The home had a licensed capacity of 150 beds and did not meet the exceptions to the requirement, as stated in section 45 of the regulation.

During an interview, a Receptionist said they were responsible for calling the agency for staffing replacements and the shifts were booked a couple of days in advance of the shift required to be filled.

During an interview, the Director of Resident Care (DORC) said the home had a good complement of registered nurses but they did not always provide their availability so the home utilized an employment agency for registered nurse coverage.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related non-compliance.

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of August, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MARIAN MACDONALD

Service Area Office / Bureau régional de services : London Service Area Office