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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2019	2019_755728_0003	024470-17, 004112-18, 024641-18	Complaint

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

MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 11-15, 19-22, 25-26, 2019.

The following intakes were completed in this complaint inspection:
Log #004112-18, related to alleged improper transfer resulting in injury and alleged improper care;
Log #024470-17, related to alleged improper care; and,
Log #024641-18, related to alleged improper care.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer (COO), the Director of Resident Care (DoRC), the Assistant Director of Resident Care (ADoRC), the Attending Physician (MD), the Clinical Auditor, the Physiotherapist (PT), the Resident Assessment Instrument (RAI) Coordinator, the RAI back-up, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeepers.

The inspector(s) reviewed clinical records and plans of care for relevant residents and pertinent policies and procedures.

Observations were made of staff to resident interactions and provision of care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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	Légende 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC) that documented a concern regarding the administration of specified medications to resident #001.

Resident #001's plan of care documented an order that stated they were to receive a specified medication once daily, as needed (PRN).

A review of resident #001's medication administration record (MAR) documented that they received the specified medication two times within the day on four separate occasions.

RPN #105 said that the resident received this medication twice in error and that it should have only been given once daily. DoRC #101 said that resident #001 should have only received the specified medication once and that they received it twice on four separate occasions.

The licensee has failed to ensure that resident #001 was administered a specified medication in accordance with the directions for use as specified by the prescriber. [s. 131. (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 to ensure that drugs are administered to a residents in accordance with the directions for use specified by the prescriber, 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the MOHLTC that documented that the substitute decision maker's (SDM) were not notified when resident #001 received a specified medication. They stated that their agreement with the home included the expectation that the SDM's would be notified when a specified medication was given.

Resident #001's plan of care documented that the SDM's should be called when the specified medication had been administered and the reason.

Resident #001's MAR documented that they had received the specified medication twenty-five times over approximately a two month period. Progress notes documented the reason resident #001 received the specified medication; however, they did not document that the SDM's were called as indicated in the plan of care.

COO #100 stated that notification of the SDM's for the specified medication order was missed because the MAR did not direct staff to call the SDM's.

The licensee has failed to ensure that the SDM's for resident #001 were contacted when a specified medication was provided to the resident and the reason why as indicated in their plan of care. [s. 6. (7)]

Issued on this 22nd day of March, 2019

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

Original report signed by the inspector.