Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 6, 2020	2020_792659_0011	022041-19, 000661-20, 001068-20, 002934-20, 004266-20, 012141-20	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

JANETM EVANS (659), AMANDA COULTER (694)

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): June 11, 12, 15,16, 17 and 18, 2020.

The following intakes were included as part of this inspection:
Log #000661-20\AH IL-73585-AH/ CI 2580-000001-20 related to improper transfer of a resident resulting in injury
Log #001068-20\CI 2580-000004-20 related to alleged emotional abuse of a resident
Log #002934-20\CI 2580-000006-20 related to alleged physical abuse of a resident by a visitor
Log #022041-19\Follow up to CO#001 from inspection #2019_755728_0023 with Compliance due date (CDD) of January 31, 2020
Log #012141-20\CI 2580-000004-20 related to improper transfer of a resident resulting in injury
Log #004266-20\AH: IL-75185-AH/CI: 2580-000007-20 related to alleged improper touching of a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Care (DoRC), Assistant Director of Resident Care (ADoRC), Social Worker (SW), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Screening staff and residents.

Observations were made related to resident to resident interactions, staff to resident interactions, general care and appearance of residents and infection prevention and control practices.

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

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

- **2 WN(s)**
- **0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A follow up inspection related to CO#001 from inspection #2019_755728_0023 with CDD Jan 31, 2020, was conducted concurrently with the critical incident (CI) inspection.

Clinical records and an incident report identified that on a specified date, resident #005 entered a co-resident #002's room which lead to an altercation between the two residents. At the time of the initial incident there were no injuries noted. However, later resident #002 showed visible signs of injury. Resident #002 told staff their injury was caused from the altercation with resident #005.

ADoRC #103 confirmed a CI was not submitted for this incident.

The licensee failed to ensure that the altercation between resident #002 and #005 which lead to an injury, was reported to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #001 and #003.

A call was made to the after hours reporting line on a specified date to report resident #001's fall.

The CI stated that a PSW had transferred resident #001 without having a second person assist with the transfer. Resident #001 sustained an injury as a result of an improper transfer and fall.

Review of resident #001's plan of care showed the resident required two person physical assistance for transfers and one person physical assistance for the bathing process.

Review of the manufacturer's instructions related to the use of the transfer device documented numerous warnings and safety measures related to the use of the device.

Review of the home's policy on resident lifting, transferring and repositioning, dated as reviewed April 2019, stated that all transfers using mechanical devices required two staff members to assist.

The home's investigation and employee discipline notice for this incident, documented the staff member did not follow the manufacturers instructions for the use of the transfer device and that the transfer was completed with assistance of one staff when there should have been two.

RPN #110, ADORC #103 and PSW #104 stated that resident #001 required a transfer device for bathing and two persons were to assist the resident with the transfer. They acknowledged there had not been a second person assist with resident #001's transfer. ADoRC #103 acknowledged the staff member did not follow manufacturer's instructions for use of the transfer device, nor had they followed the home's policy.

2. A fall risk assessment for resident #003, documented that the resident was at moderate risk for falls.

The plan of care for resident #003 documented that the resident required assistance of two persons and a mechanical lift could be used for transfers.

On a specified date, resident #003 requested assistance from PSW #105 as they were uncomfortable. PSW #105 stood resident #003 at a grab bar, when resident #003's legs gave out and they fell. Resident #003 was initially assessed to have no injury but complained of pain. They were transferred to hospital for assessment and no injury was found. Assessment a few days later documented an injury.

PSW #105 acknowledged that there were no other staff present to assist resident #003 with the transfer at the time of this incident.

RPN #106 stated that resident #003 required two person assistance for all transfers. At the time of the fall there was one staff present.

The licensee failed to ensure that staff used safe transferring techniques when assisting resident #001 and #003 with transfers which resulted in injury to the residents. [s. 36.]

Additional Required Actions:

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

Issued on this 15th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2020_792659_0011
Log No. / No de registre :	022041-19, 000661-20, 001068-20, 002934-20, 004266-20, 012141-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 6, 2020
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

To Lutheran Homes Kitchener-Waterloo, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0023, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that all incidents of alleged, suspected, or witnessed abuse are immediately reported to the Director.

Grounds / Motifs :

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

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

1. A follow up inspection related to CO#001 from inspection #2019_755728_0023 with CDD Jan 31, 2020, was conducted concurrently with the critical incident (CI) inspection.

Clinical records and an incident report identified that on a specified date, resident #005 entered a co-resident #002's room which lead to an altercation between the two residents. At the time of the initial incident there were no injuries noted. However, later resident #002 showed visible signs of injury. Resident #002 told staff their injury was caused from the altercation with resident #005.

ADoRC #103 confirmed a CI was not submitted for this incident.

The licensee failed to ensure that the altercation between resident #002 and #005 which lead to an injury, was reported to the Director. [s. 24. (1)]

The severity of this issue was two, minimal risk. The scope of this issue was one as the issue was isolated to one of three resident's reviewed. The compliance history for this issue was four as the home had previous related non compliance in the last 36 months, which included: a Compliance Order and Written Notification (WN) issued in complaint inspection 2019_755728_0023, with a compliance due date (CDD) of January 31, 2020. (694) (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2020

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg. 79/10.

Specifically, the licensee shall ensure that:
a. Staff follow the manufacturer's instructions when the bath lift chair is used for a resident transfer.
b. Staff follow the home's lifts and transfers policy, related to ensuring two staff are present throughout the entire transfer when a bath lift is being used.
c. Staff follow the resident's plan of care related to the level of assistance required for the resident's transfer.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #001 and #003.

A call was made to the after hours reporting line on a specified date to report resident #001's fall in the tub room.

The CI stated that a PSW had transferred resident #001 from the tub, without having a second person assist with the transfer. Resident #001 sustained an injury as a result of an improper transfer and fall.

Review of resident #001's plan of care showed the resident required two person physical assistance for transfers and one person physical assistance for the bathing process.

Review of the manufacturer's instructions related to the use of the transfer device documented numerous warnings and safety measures related to the use

of the device.

Review of the home's policy on resident lifting, transferring and repositioning, dated as reviewed April 2019, stated that all transfers using mechanical devices required two staff members to assist.

The home's investigation and employee discipline notice for this incident, documented the staff member did not follow the manufacturers instructions for the use of the transfer device and that the transfer was completed with assistance of one staff when there should have been two.

RPN #110, ADORC #103 and PSW #104 stated that resident #001 required a transfer device for bathing and two persons were to assist the resident with the transfer into the tub. They acknowledged there had not been a second person assist with resident #001's transfer. ADoRC #103 stated that from their investigation disciplinary action was taken as the PSW involved in the incident had not followed the manufacturer's instructions for use of the transfer device, nor had they followed the home's policy [s. 36.] (659)

2. A fall risk assessment for resident #003, documented that the resident was at moderate risk for falls.

The plan of care for resident #003 documented that the resident required assistance of two persons and a mechanical lift could be used for transfers.

On a specified date, resident #003 requested assistance from PSW #105 as they were uncomfortable. PSW #105 stood resident #003 at a grab bar, when resident #003's legs gave out and they fell. Resident #003 was initially assessed to have no injury but complained of pain. They were transferred to hospital for assessment and no injury was found. Assessment a few days later documented an injury.

PSW #105 acknowledged that there were no other staff present to assist resident #003 with the transfer at the time of this incident.

RPN #106 stated that resident #003 required two person assistance for all transfers. At the time of the fall there was one staff present.

The licensee failed to ensure that staff used safe transferring techniques when assisting resident #001 and #003 with transfers which resulted in injury to the residents. [s. 36.]

The severity of this issue was three, actual harm, as both residents sustained injuries from their fall. The scope of the issue was two, a pattern, as two of three residents reviewed had been transferred in an unsafe manner. The home's compliance history was two, as the home had a history of non compliance to an unrelated area. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 01, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Central West Service Area Office