



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de
London
291, rue King, 4ⁱème étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2014	2014_271532_0005	L-000106-14	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

NUZHAT UDDIN (532)

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): February 12, 2014

During the course of the inspection, the inspector(s) spoke with Chief Operating Officer, Director of Resident Care, Registered Practical Nurse, Registered Nurse and Personal Support Workers.

During the course of the inspection, the inspector(s) toured the resident home area, reviewed the medical records and monitored staff-to-resident interactions during the provision of care.

The following Inspection Protocols were used during this inspection:



1. The licensee of the long term care home failed to ensure that a resident was not neglected by the licensee or staff.

A review of the licensee's compliance history revealed that the licensee has existing non-compliance in this areas.

In January 2014 a resident was assisted on the toilet. A Personal Support Worker (PSW) went back to check on the resident and the resident required more time. The PSW left the resident sitting on the toilet with the sit to stand lift in front of them and left the room. PSW failed to return to the resident before the end of their shift. An evening PSW discovered the resident sitting on the toilet. It was confirmed that the resident was left on the toilet for extended period of time.

An assessment of the resident revealed that the resident had a noticeable outline of toilet seat ring around the buttock area.

Staff failed to provide the resident with care and assistance required for health, safety or well-being and the Director of Resident Care (DRC) confirmed that inaction of staff occurred for an extended period of time. [s. 19. (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. 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 :



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1. The licensee of a long term care home failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A record review revealed that the resident did not have the ability to control urination, the resident was not able to express and share information related to decline in cognitive status and the skin was characterized by rashes related to incontinence. Review of the plan of care revealed that the resident required assistance for the physical process of toileting. The plan of care did not indicate that resident should not be left unattended; however, RPN confirmed that since the incident staff would not leave the resident in the bathroom unattended.

Observations revealed that the kardex posted in the closet indicated that the resident was one person constant assist, however, the plan of care and the RPN confirmed that the resident was two person constant physical assist for safety using sit to stand lift. RPN confirmed that there was no continence assessment conducted on the resident prior to or after the incident. Record review and interview with the RPN confirmed that an assessment was not conducted using a clinically appropriate assessment that was specifically designed for assessment of incontinence. [s. 51. (2) (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 The licensee of a long term care home shall ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



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Issued on this 21st day of February, 2014

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

A handwritten signature in black ink, appearing to read "Margaret L. I.", written in a cursive style.



Ministry of Health and
Long-Term Care

Ministère de la Santé et
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

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

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : NUZHAT UDDIN (532)

Inspection No. /

No de l'inspection : 2014_271532_0005

Log No. /

Registre no: L-000106-14

Type of Inspection /

Genre

d'inspection:

Critical Incident System

Report Date(s) /

Date(s) du Rapport : Feb 21, 2014

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 : JEANNE JACKSON

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



**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

**Ministère de la Santé et
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Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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section 154 of the *Long-Term Care
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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
Performance Improvement and Compliance
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.



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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

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
Direction de l'amélioration de la performance et de la
conformité
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 21st day of February, 2014

Signature of Inspector / *Nuzhat Uddin*
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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