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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2015	2015_271532_0013	L-002168-15	Resident Quality Inspection

Licensee/Titulaire de permis

SAINT LUKE'S PLACE
1624 Franklin Blvd. CAMBRIDGE ON N3C 3P4

Long-Term Care Home/Foyer de soins de longue durée

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD CAMBRIDGE ON N3C 3P4

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

NUZHAT UDDIN (532), DOROTHY GINTHER (568), REBECCA DEWITTE (521)

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): April 13, 14, 15, 16, 17, 21, 22, 23, 24, 2015

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Director of Support Services (DSS), Director of Recreation and Volunteer Services, Environmental Services Manager, Best Practice Coordinator, Resident Assessment Instrument (RAI) Coordinator, Infection Prevention and Control Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary aide, Recreation Care Aide, Housekeeping and Maintenance staff , Family and Resident Council Representatives.
Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **1 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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the resident.

A) During observation of the noon meal on an identified home area the following was observed:

Dietary staff worked behind the counter to plate the meal while nursing staff served the residents. At no time during the dining service were nursing or dietary staff observed checking the diet book which was available to them. The Dietary Aide confirmed that she did not reference the diet book and reported that only the staff who were unsure of a residents' diet were advised to check the book.

Record Review indicated that a concern was raised by the Food committee members regarding residents not receiving the proper texture at meals, however, there were no actions documented in the minutes to indicate how this concern was being addressed.

Personal Support Workers were observed carrying soup and meals from the main dining room to the small recreation room down the hall where three residents were having their lunch. Neither the soup nor the meals were covered.

Desserts were being served before residents had finished their main course. The Dietary Aide was observed to bring resident's dessert while they were still eating their main course at the noon meal. A Personal Support Worker assisting another resident at the same table asked the Dietary Aide to please put it to the side, as residents were not finished their main course.

Interview with the Dietary Aide confirmed that it was the homes' expectation that meals be served course by course to avoid rushing residents; and food items being delivered to residents outside the main dining room should be covered.

Trays were being prepared and delivered to residents in their rooms while there were still residents in the dining room that had not been served their main course. This process delayed meal service for those residents in the dining room.

During observation of the noon meal on an identified home area the following was observed:

Staff were observed and confirmed during interview that they left during the lunch meal

service to go on their break. Residents were still being served and/or required assistance when the staff members left the dining room. The last table of residents were not served the main course until 1248 hours having waited almost 30 minutes.

Several residents were observed sleeping throughout meal service in the dining room. Observation revealed that they had eaten very little of the main course. Midway through the meal a Personal Support Worker that was in the process of recording what residents had consumed woke an identified Resident to find out if they were planning on eating their main course so the staff member could document consumption. The identified Resident replied "yes" and the staff member left the resident who returned to sleep. Ten minutes later the Dietary Aide woke the same Resident to ask for their preference for dessert. When the resident indicated their preference, the staff member placed the dish on the plate with the unfinished main course.

Review of the identified Resident's plan of care indicated that nursing would provide assistance with setup at the beginning of the meal, cut-up meat as needed and offer intermittent encouragement throughout the meal, however, it was noted that the Resident was not offered encouragement or assistance.

It was not until 1250 hours after the staff member finished assisting the two other residents and escorted them back to their room, that the staff provided physical assistance to the identified resident. At 1250 hours the staff member returned to the dining room and was observed feeding the identified Resident. Staff interview with the Registered Practical Nurse revealed that the identified Resident required increased care and they had done fine with breakfast but required assistance with lunch. The registered staff further acknowledged that they were still in the process of assessing this resident to determine the care needs for activities of daily living.

Review of the Resident's Council Minutes revealed a concern brought forward regarding an identified dining room and the residents need for assistance. The council was concerned that residents that needed assistance with cutting their food and getting set up with the meal were not always provided this assistance in a timely manner. A member of the council indicated that they have had frequent conversations about meals being late, as well as the need for more staff in order to ensure that residents get the assistance they need for meals. The member of the council reported that there were a lot of residents that needed some degree of assistance and when staff were not available to assist these residents, they were not able to eat their meal independently.

Review of the Food Committee Minutes revealed a number of concerns brought forward by residents regarding the home's organized program of nutrition and dietary services. There was no documentation in the Food Committee minutes to indicate how these concerns were being addressed. A member of the Food Committee shared that there were ongoing concerns regarding the dining service, on an identified home area.

During a meeting with the home's Support Services Manager, Director of Care and the CEO concerns regarding the dining service were discussed. The Director of Care acknowledged that she was not aware that nursing staff were taking breaks during meal service and confirmed that this was not the home's practice. The CEO confirmed that they were working towards an organized program of nutrition care and dietary services for the residents in the home. [s. 11. (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 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 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:
9. Every resident has the right to have his or her participation in decision-making respected. 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 are fully respected and promoted; every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

A) Observations of the medication pass on an identified home area revealed the following:

Two identified residents had orders for a treatment to be administered twice daily. The treatment was administered to the identified residents in the dining room in front of other residents.

Clinical record review for the above Residents revealed that the treatments that were administered in the dining room were not documented in the plan of care as to be given in the common area.

In an interview the Director of Care confirmed that all treatments were to be given out of the dining room for privacy and acknowledged that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

2. The licensee failed to ensure the following rights of residents are fully respected and promoted; every resident has the right to have his or her participation in decision-making respected.

A) Observations during the medication administration pass revealed that an identified resident was clamping their mouth closed when the Registered Practical Nurse (RPN) attempted to provide medication. The RPN continued to try and give the resident the medication despite the residents resistance to taking the medication.

An interview with the Director of Care confirmed the Resident has the right to have his or her participation in decision-making respected. [s. 3. (1) 9.]

3. The licensee failed to ensure the Resident's 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.

A) Observations of the medication pass revealed the E-MAR terminal displaying resident's health information was left open and unlocked four times during the Resident Quality Inspection (RQI) period.

On an another identified date it was observed by inspector #532 that the E-mar terminal screen was left open displaying resident health information.

An interview with the Director of Care confirmed that it was the homes expectation to ensure the E-MAR terminal was closed and locked when not in use and acknowledged that the Residents' should have his or her personal health information kept confidential in

accordance with that Act. [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:
Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs; Every resident has the right to have his or her participation in decision-making respected;
Resident's 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, to be implemented voluntarily.

WN #3: 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

A) The plan of care for an identified Resident revealed that the Resident should be offered activities of which the resident had shown interest and provision of one to one sessions one to two times per week by recreation staff.

Record review revealed for the period in 2015 the resident did not receive one to one sessions by recreation staff as outlined in the plan of care.

Staff interview with the Recreation Aide revealed that there used to be a dedicated Recreation Aide for each of the four floors, however, that had changed as of spring 2014 and this made it very difficult to continue the regular programming in addition to the one to one visits. Recreation staff confirmed that they were not able to provide the one to one visits as specified in the plan of care for the identified Resident. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provide direct care to the resident, are kept aware of the contents of the plan of care and have convenient and immediate access to it.

A) Record review revealed an identified resident tended to be incontinent daily but some control was present.

Interview with a Personal Support Worker revealed that they were not aware that the resident was on a specific toileting schedule. When asked where staff get their direction for individual resident care needs such as toileting, the staff member indicated that there was an information sheet on the inside of the residents' closet door which provided some direction and when they document in Point of Care.

Observation of the identified resident closet door revealed there was no information or schedule that outlined specific times to toilet the resident.

Point of Care was also reviewed and there were no toileting times identified for the resident.

The Director of Care confirmed that while the toileting times for those residents' on a specific toileting schedule were documented on the care plan, front line care staff do not have convenient and immediate access to it. [s. 6. (8)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary.

A) Record review revealed that and identified resident sustained a fall with injury.

Staff interview with two Personal Support Workers revealed that since the identified residents' fall the resident transfer status had changed. Staff indicated that a residents' transfer status was usually documented on the Kardex in Point of Care, as well as on the residents' information sheet posted inside their closet door. This information provided them with direction related to specific care issues.

A review of the Resident's plan of care and the information sheet posted inside the Resident's closet stated two different transfer status than what the staff had reported.

The Best Practice Coordinator acknowledged that the Resident's plan of care with regards to transfers was not updated and the identified Resident was not reassessed and the plan of care was not reviewed and revised when the residents' care needs had changed. (568)

B) Record review revealed an identified Resident had a fall and sustained an injury. A significant change Minimum Data Set (MDS) assessment was completed and the assessment indicated that the resident's continence had deteriorated and they were now incontinent.

Staff interview with a Personal Support Worker revealed that staff have not been toileting the identified resident because of the sustained injury.

Review of the plan of care related to toileting and continence and the information sheet posted inside the identified resident's closet, both indicated different continence status.

The Best Practice Coordinator acknowledged that the Resident's continence had deteriorated following their injury and confirmed that the resident's plan of care related to continence and toileting had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 the plan of care sets out clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan;to ensure that staff and others who provide direct care to the resident, are kept aware of the contents of the plan of care and have convenient and immediate access to it and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A) The home's policy named "Fall Prevention and Management" stated under Registered Nursing staff: Initiate Head Injury Routine (HIR) as per protocol for all un-witnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.

Record review revealed that an identified resident had an un-witnessed fall, where the resident was found on floor.

Record review indicated that there was no HIR initiated for the un-witnessed fall.

Registered Practical Nurse(RPN) and Best Practice Coordinator reported that HIR were only completed if a visible head injury was observed on a resident or a resident indicated to the staff that they hit their head. Otherwise the HIR were not being completed for all un-witnessed falls.

The Director of Care confirmed that the staff were not completing the HIR for all un-witnessed falls as per protocol. The DOC reported that she did not expect the registered staff to complete the HIR for every fall i.e. if a resident rolls out of bed. The DOC further reported that she plans to change the policy to reflect what the staff were doing and confirmed that the policies were not complied with. (532)

B) The home's policy named Continence Assessment and Care stated that every resident shall be clean and dry with every effort made to maintain dignity, comfort and independence. In order to comply with this standard residents' will be reassessed at least quarterly and as their condition changes to ensure that appropriate interventions are in place.

Record review and staff interview revealed that an identified Resident sustained a fall with injury.
Clinical record review did not reveal continence assessment for the identified Resident.

The Best Practice Coordinator acknowledged that the Resident continence for both urine and bowel had deteriorated since their fall and that a continence assessment should have been completed for the resident given their change in condition.

The home failed to comply with their Continence Assessment and Care policy which indicated that a resident was to be reassessed as their condition changed to ensure appropriate interventions were in place. (568)

C) The home's policy named Pain Management outlined the following under the procedure:
Residents have a pain assessment done upon admission/re-admission, quarterly and when pain is indicated by verbal complaint or observation of behaviour change or

condition change, including acute illnesses and end of life care.

Clinical record review revealed that an identified Resident sustained a fall with injury. There was no evidence during the record review that the Resident had a Pain Assessment completed.

Staff interview with the Best Practice Coordinator revealed that when a resident sustained a fall with injury it was the home's expectation that the identified resident would have a seven day Pain Assessment completed when they had a change in condition. The staff member acknowledged that a Pain Assessment should have been completed for the identified Resident and confirmed that it had not been done.

The home failed to ensure that the Pain Management Policy # N-I-S-80 was complied with. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: 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 is equipped with a resident-staff communication and response system that 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.

A) During stage 1 of the Resident Quality Inspection, call bells in the identified resident's rooms and adjoining bathrooms were tested. It was noted that while the call bell lights connected to these resident rooms and adjoining bathrooms were visible when activated, the sound component was not audible.

A staff interview with the two Personal Support Workers reported that they had not noticed that the call bells in the identified rooms were not audible. Usually they noticed the lights above the room flashing and if not the registered staff informed them when someone needed assistance.

The Director of Care confirmed that the communication response system in the identified resident's rooms and adjoining bathrooms were not audible to all staff.

In an interview the Environmental Services Manager revealed that the call bell system was audited by an outside company on a yearly basis. The Environmental Services Manager indicated that when the communication response system was installed a number of years ago the toner component of the system was located near the main console in front of the nursing station. The result was that for rooms that are a greater distance away from the console the sound component of the system was more difficult to hear. When the system was first installed staff were using pagers so this may not have been noticed. In the last 12-18 months the pagers were discontinued and staff now rely on the visible and audible components of the call system to alert them when a resident was needing assistance.

The Environmental Services Manager indicated that repairs to the toner component of the communication response system have been scheduled for early May 2015.

The home was not equipped with a resident-staff communication response system that was audible to all staff. [s. 17. (1) (g)]

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 home is equipped with a resident-staff communication and response system that 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, to be implemented voluntarily.

WN #6: 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 drugs are stored in an area or a medication cart, that is secure and locked.

A) Observations made on three different dates by two different Inspectors revealed that the medication cart was left unlocked, un-secured and un-attended. Medication cart was parked outside of dining area where there were other residents in close proximity and no registered staff in sight. The RPN was observed coming down the hall and confirmed that the expectation was to have the medication cart locked up at all times. (532)

During a debrief meeting the DOC confirmed it was the home's expectation to have drugs stored in an area or a medication cart, that was secure and locked. [s. 129. (1) (a)]

B) Observation of a Medication Pass revealed an open packet containing a medication was left on top of the medication cart while the Registered Practical Nurse left the cart to administer medications in the dining room. The medication cart was left unlocked and unattended.

An interview with the Director of Care on April 17, 2015, confirmed that it was the homes' expectation that drugs were stored in an area or a medication cart, that was secure and locked.

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 stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participates in the implementation of the infection prevention and control program.

A) Observations in identified resident shared bathrooms found that residents' personal care items were unlabeled.

In an interview a Registered Practical Nurse(RPN) confirmed that the expectation was that all resident personal care items were to be labelled and she further reported that she will be asking the staff to label them. (532)

B) During a medication administration pass observations revealed a fresh urine sample was sitting on the medication cart next to the open lid of apple sauce and a jug of drinking water.

The Registered staff member was observed administering a treatment to an identified resident without washing their hands first.

The Registered staff member left a blood soiled tissue on the dining room table during the meal.

The Registered Practical Nurse was observed to remove a medication from a blister pack using their fingers.

An interview with the Director of Care confirmed that it was the home's expectation that the staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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 staff participates in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents. 2007, c. 8, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an organized recreational and social activities program meet the interests of the residents.

A) During stage one of the Resident Quality Inspection two identified residents reported a lack of activities occurring on the weekend.

Review of the activities calendar for March and April 2015 revealed that programs were only offered on two out of the four Saturdays in the three home areas. One home area had programs offered on one out of the four Saturdays during the month. There were no programs offered on Sundays except for Catholic Communion which was organized by the pastoral care department.

The Recreation Manager confirmed that programs were offered only on two out of the four Saturdays during the month for three of the home areas and one out of four Saturdays for another home area. There were no social activities programs arranged for Sundays by the Recreation department to meet the interests of the residents. (568) [s. 10. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations was completed.

A) In an interview one of the Resident Council members shared that if there was a concern that was shared at the meeting, then they would get the information back at the next meeting.

The Resident Council Chair also reported that the response to the concerns were not within the 10 days.

Minutes to the Resident Council were reviewed and revealed that there were concerns raised, however, the response was not documented within 10 days of receiving the concern and it was not included in the minutes of the Resident Council meetings.

The DOC in an interview confirmed that concerns were being addressed as they were being raised however, she was not aware of responding in writing to the council within 10 days.

The Chief Executive Officer (CEO)confirmed that the response to the concerns were not in writing within 10 days and developed a form that will reflect the response in an efficient manner. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing within 10 days of receiving Family Council advice related to concerns or recommendation was completed

A) In an interview the Family Council Chair shared that the Family Council members did raise concerns at the meetings and the home's representative would take the concerns back to the respective manager. The home's representative then brings the response back to the next meeting.

Minutes to the Family Council were reviewed and revealed that there were concerns raised, however, the response was not documented within 10 days of receiving the concern and it was not included in the minutes of the Family Council meetings.

The DOC in an interview confirmed that concerns were being addressed as they were being raised however, she was not aware of responding in writing to the council within 10 days.

The Chief Executive Officer (CEO)confirmed that the response to the concerns were not in writing within 10 days and developed a form that will reflect the response in an efficient manner. [s. 60. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times;

A) Observations on an identified home area revealed a cleaning cart left unattended with "Lean Green" disinfectant sitting out on the cart and an open bucket with water. The inspector was unable to locate a housekeeper.

Observations on an identified home area revealed a cleaning cart left unattended in the hallway with a bucket of blue water and mop on the opposite side, this was brought to the attention of the RPN who called the housekeeping staff who had gone on break leaving the bucket in the hallway.

In an interview the Support Services Manager confirmed the bucket would have a floor cleaning solution with the water and further stated that there was a potential risk and confirmed that it was the homes expectation that the hazardous substances were kept inaccessible to the resident at all times. [s. 91.]

Issued on this 5th day of May, 2015

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

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), DOROTHY GINTHER (568), REBECCA DEWITTE (521)
Inspection No. / No de l'inspection :	2015_271532_0013
Log No. / Registre no:	L-002168-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 1, 2015
Licensee / Titulaire de permis :	SAINT LUKE'S PLACE 1624 Franklin Blvd., CAMBRIDGE, ON, N3C-3P4
LTC Home / Foyer de SLD :	SAINT LUKE'S PLACE 1624 FRANKLIN BOULEVARD, CAMBRIDGE, ON, N3C-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brian Swainson

To SAINT LUKE'S PLACE, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents:
1. Monitoring of all residents during meals i.e. residents receiving assistance in timely manner and providing personal assistance and encouragement required for residents.
2. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and are following the process to ensure residents are receiving correct diets by the residents assessed needs and sufficient time is provided to eat at his or her own pace.
3. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the residents assessed needs.

Grounds / Motifs :

1. The licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the resident.

A) Two voluntary plans of correction were previously issued at the last Resident Quality Inspection, February 24, 2014 related to O. Reg 79/10, s. 73 (1) 1. and 8. weekly and daily menus and course by course service and O. Reg 79/10, s 8. (1) (b) policies related to "Meal Times" and "Meal Service Table Rotation" were

not complied with.

During observation of the noon meal on an identified home area the following was observed:

Dietary staff worked behind the counter to plate the meal while nursing staff served the residents. At no time during the dining service were nursing or dietary staff observed checking the diet book which was available to them. The Dietary Aide confirmed that she did not reference the diet book and reported that only the staff who were unsure of a residents' diet were advised to check the book.

Record Review indicated that a concern was raised by the Food committee members regarding residents not receiving the proper texture at meals, however, there were no actions documented in the minutes to indicate how this concern was being addressed.

Personal Support Workers were observed carrying soup and meals from the main dining room to the small recreation room down the hall where three residents were having their lunch. Neither the soup nor the meals were covered.

Desserts were being served before residents had finished their main course. The Dietary Aide was observed to bring resident's dessert while they were still eating their main course at the noon meal. A Personal Support Worker assisting another resident at the same table asked the Dietary Aide to please put it to the side, as residents were not finished their main course.

Interview with the Dietary Aide confirmed that it was the homes' expectation that meals be served course by course to avoid rushing residents; and food items being delivered to residents outside the main dining room should be covered.

Trays were being prepared and delivered to residents in their rooms while there were still residents in the dining room that had not been served their main course. This process delayed meal service for those residents in the dining room.

During observation of the noon meal on an identified home area the following was observed:

Staff were observed and confirmed during interview that they left during the lunch meal service to go on their break. Residents were still being served and/or required assistance when the staff members left the dining room. The last table of residents were not served the main course until 1248 hours having waited almost 30 minutes.

Several residents were observed sleeping throughout meal service in the dining room. Observation revealed that they had eaten very little of the main course. Midway through the meal a Personal Support Worker that was in the process of recording what residents had consumed woke an identified Resident to find out if they were planning on eating their main course so the staff member could document consumption. The identified Resident replied "yes" and the staff member left the resident who returned to sleep. Ten minutes later the Dietary Aide woke the same Resident to ask for their preference for dessert. When the resident indicated their preference, the staff member placed the dish on the plate with the unfinished main course.

Review of the identified Resident's plan of care indicated that nursing would provide assistance with setup at the beginning of the meal, cut-up meat as needed and offer intermittent encouragement throughout the meal, however, it was noted that the Resident was not offered encouragement or assistance.

It was not until 1250 hours after the staff member finished assisting the two other residents and escorted them back to their room, that the staff provided physical assistance to the identified resident. At 1250 hours the staff member returned to the dining room and was observed feeding the identified Resident. Staff interview with the Registered Practical Nurse revealed that the identified Resident required increased care and they had done fine with breakfast but required assistance with lunch. The registered staff further acknowledged that they were still in the process of assessing this resident to determine the care needs for activities of daily living.

Review of the Resident's Council Minutes revealed a concern brought forward regarding an identified dining room and the residents need for assistance. The council was concerned that residents that needed assistance with cutting their food and getting set up with the meal were not always provided this assistance in a timely manner. A member of the council indicated that they have had frequent conversations about meals being late, as well as the need for more

staff in order to ensure that residents get the assistance they need for meals. The member of the council indicated that there were a lot of residents that needed some degree of assistance and when staff were not available to assist these residents, they were not able to eat their meal independently.

Review of the Food Committee Minutes revealed a number of concerns brought forward by residents regarding the home's organized program of nutrition and dietary services. There was no documentation in the Food Committee minutes to indicate how these concerns were being addressed. A member of the Food Committee shared that there were ongoing concerns regarding the dining service, on an identified home area.

During a meeting with the home's Support Services Manager, Director of Care and the CEO concerns regarding the dining service were discussed. The Director of Care acknowledged that she was not aware that nursing staff were taking breaks during meal service and confirmed that this was not the home's practice. The CEO confirmed that they were working towards an organized program of nutrition care and dietary services for the residents in the home. [s. 11. (1)] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2015

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
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

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.

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
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

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
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 1st day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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