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**


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

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

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 24, 2016 | 2016_263524_0020 | 015927-16 | 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**

INA REYNOLDS (524), DONNA TIERNEY (569), MELANIE NORTHEY (563), NANCY JOHNSON (538), SHERRI COOK (633)

## 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): May 31, June 1, 2, 3, 6, 7, 8, 9, 13, 14, 15, 16, 2016.**

**The following intakes were completed within the RQI:**
**Log # 009470-15 Follow-up related to dietary services**
**Log # 036085-15 / IL-42179-LO Complaint related to responsive behaviours**
**Log # 022793-15 / C568-000018-15 Critical incident related to a fall resulting in a**

**fracture**
**Log # 001338-16 / C568-000001-16 Critical incident related to allegations of staff to resident abuse**
**Log # 022360-15 / C568-000017-15 Critical incident related to a fall resulting in a fracture**
**Log # 028727-15 / C568-000019-15 Critical incident related to a fall resulting in a fracture**
**Log # 015677-16 / C568-000002-16 Critical incident related to a fall resulting in a fracture**
**Log # 015687-16 / C568-000006-16 Critical incident related to a fall resulting in a fracture**
**Log # 015744-16 / C568-000001-15 Critical incident related to allegations of financial abuse**
**Log # 016800-16 / C568-000009-16 Critical incident related to allegations of staff to resident abuse**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, Director of Support Services, Manager of Human Resources, two Assistant Directors of Care, Director of Finance, Director of Recreation and Volunteer Services, Associate Director of Support Services, Best Practice Coordinator, Resident Assessment Instrument Coordinator, one Pharmacist, one Registered Dietitian, one Registered Nurse, eight Registered Practical Nurses, seventeen Personal Support Workers, two Dietary Aides, two Recreation Care Aides, two Housekeeping Aides, one Maintenance staff, two Laundry Aides, one Accounts Receivable Clerk, Family and Resident Council Representatives and 44 Residents.**

**The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal and snack service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, internal investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 11. (1) | CO #001 | 2015_271532_0013 | 524 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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 staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A) Record review on June 7, 2016, of a resident's diagnoses indicated that the resident had a specific identified diagnosis. Record review of the most current care plan for the resident indicated multiple Personal Support Worker (PSW) interventions for reducing and preventing a decline for this diagnosis.

Staff interview with a PSW shared that in order to provide care to residents, the PSWs refer to the kardex in Point of Care (POC). Upon review of the POC kardex by the PSW and the Inspector there were no headings observed related to the identified interventions for the resident. Staff interview with a Registered Practical Nurse (RPN) agreed that the identified interventions for the resident were not listed on the kardex for the personal support workers.

B) Record review of the Personal Support Worker (PSW) kardex in Point of Care (POC) on June 14, 2016, for an identified resident demonstrated the care plan interventions related to behavior care to be provided to the resident by PSW staff were not documented in the kardex for PSWs to reference.

Staff interview with Personal Support Worker (PSW) agreed that interventions for this resident were not listed on the kardex in POC for the personal support workers.

C) Record review on June 7, 2016, of the current care plan in PointClickCare (PCC) for an identified resident revealed numerous interventions related to specific care needs.

Record review of the kardex in PCC on June 7, 2016, for the resident revealed that these specific care need interventions were not included.

Staff interview and record review with two PSWs on a specific date and time, revealed that PSW staff did not have access to the resident's care plan and interventions for the identified resident were not present on the kardex for PSW immediate access.

D) Record review of the current care plan in PCC on June 7, 2016, for an identified resident stated multiple specific care plan interventions related to personal hygiene/oral care and skin integrity.

Record review of the PSW kardex in PCC on June 7, 2016, for the resident stated under the "Personal Hygiene/Oral Care" focus "ADL- Bathing and ADL- Dressing" and there were no interventions related to skin monitoring in the PSW kardex. The care plan interventions related to oral care and skin care to be provided to the resident by PSW staff were not documented in the kardex for PSWs to reference.

Record review of the current care plan in PCC on June 7, 2016, for an identified resident stated specific care plan interventions related to oral care and continence care. Record review of the PSW kardex in PCC on June 7, 2016, for the resident indicate that the care plan interventions related to oral care and continence care to be provided to the resident by PSW staff were not documented in the kardex for PSWs to reference.

Staff interview was conducted with the Assistant Director of Care (ADOC) on June 7, 2016. The ADOC said that PSWs do have access to some information on the kardex, but agreed the interventions outlined in the care plan for PSWs were not all pulled over to the kardex from the care plan. The ADOC said that care plans were not printed and for interventions not outlined on the kardex, PSWs must ask the RPN to print a copy of the full care plan for their review. The ADOC agreed that the PSWs did not have immediate or convenient access to the interventions in place related to care and services. [s. 6. (8)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Record review on June 7, 2016, of the most current care plan indicated that an identified resident had altered skin integrity. There was evidence of a documented intervention noted in the progress notes. Further review of the RAI-MDS quarterly review under section M Skin condition indicated altered skin integrity.

Staff interview on a specific time and date with a Registered Practical Nurse (RPN) indicated that the resident had altered skin integrity and the treatment was expected to be completed by the wound care specialist on a specific date.

Staff interview with the Best Practice Registered Practical Nurse (BP RPN) indicated that the altered skin integrity for the resident had closed over; requiring continued monitoring but no further treatment required. The BP RPN agreed that the care plan had not been updated when the care for the altered skin integrity was no longer required.

B) Record review of the current plan of care for an identified resident on June 7, 2016, identified a specific incontinent product.

Observation and staff interviews with three Personal Support Workers was conducted on specific dates and times. The PSWs said that the resident does not wear the indentified incontinence product and that the resident uses a different incontinence product on all shifts.

The resident care plan was not revised when the resident's care needs changed related to the use of incontinence product to manage urinary incontinence.

C) Record review of the plan of care under the nutrition focus and the servery dietary list for an identified resident directed staff to provide specific adaptive feeding devices with all entrees and fluids. Observation of a meal service indicated these adaptive aides were not provided to the resident. Dietary staff stated that these adaptive aides were no longer required.

The Registered Dietitian stated this care plan intervention was no longer current to reflect the resident's current status and that the plan of care should have been revised due to the change in resident's care needs related to eating. [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 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 and to ensure that the resident's plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**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 :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A) Record review of the Saint Luke's Place "Food Services Continuous Quality Improvement Audits" Policy # D702 dated January 2016, directs the dietary and nursing management to complete meal service audits based on a monthly schedule and to meet regulatory requirements. The policy directed staff to complete 6-8 audits per week to rectify any concerns and to ensure problems were not reoccurring or were overlooked.

Record review of the Food Service Audits completed May 18 and 31, 2016, revealed the following under the criteria focus: "Are residents requiring assistance with drinking and

eating only served a meal within 5 minutes of when someone is available to provide the assistance". This policy did not reflect current legislation that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Staff interview with the Director of Support Service on June 9, 2016, indicated that the Food Service audit tool should be reflective of current legislation.

B) Review of the home's "Continence Assessment and Care" Policy # N-I-J-57 with a revision date of March 2016, indicated that every resident would be reassessed at least quarterly and as the resident's condition changed.

Record review of an identified resident's Minimum Data Set (MDS) assessments revealed that their last assessment was completed on an identified date. Further review on the home's electronic charting system showed the last quarterly continence assessment for the resident was completed on an identified date.

In an interview with the Best Practice Nurse on June 8, 2016, it was acknowledged there was no continence assessment completed for the resident's MDS annual review on an identified date, and agreed that it should have been completed.

C) In an interview with a resident on a specific date, they shared that they came to the home with multiple clothing items, and now can only account for two-thirds. They also shared that they had told staff several times, but the items still had not been found and had given up on finding them. The resident reiterated the same comments on another interview conducted on another day.

In an interview with a Personal Support Worker, it was acknowledged that they were aware the resident had missing clothing items and that the items had not yet been found.

Record review of the "Lost and Found Clothing" Policy # L-062 with a revision date of February 2016, identified the following: "If the item continues to be missing, nursing will complete Residents' Lost Clothing Form A and send to Laundry" and " Laundry staff will document all missing clothing or personal items on the "lost laundry form".

During an interview with a Laundry Aide, it was acknowledged that they were aware of the resident's lost clothing items and also had been unable to locate them. When asked if there was a Residents' Lost Clothing Form completed for the resident's missing items,

the Laundry Aide looked throughout the laundry area, and then acknowledged there was not. When the Laundry Aide was asked if the resident lost clothing items were listed on the "lost laundry form", they acknowledged they were not. It was observed that the last entry on the form was dated October 27 with no year identified.

In an interview on June 15, 2016, the Director of Support Services agreed that the Resident's Lost Clothing Form and lost laundry form should have been completed for the resident's missing items as per the home's policy.

D) Record review of the Saint Luke's Place "Tray Service" policy # D109 dated November 2015, stated that "trays will be prepared by foodservice personnel after the main dining room has been served and assisted".

A meal service observation was conducted in a dining room on a specific date and time. A personal support worker delivered a tray to two residents in their rooms, while there were still residents in the dining room that had not been served their soup or main course or hot beverages.

Staff interview with the Associate Director of Support Services on June 9, 2016, indicated that food service trays were to be prepared and delivered after residents in the dining room had been served and assisted as per home's policy. [s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Staff interview was conducted with the Best Practice Registered Practical Nurse (BP RPN). The BP RPN said an identified resident exhibited altered skin integrity during a specific period of time.

A record review of the Skin/Wound Assessments completed in PointClickCare (PCC) indicated a Skin/Wound Assessment was not completed between this specific period of time for the resident's altered skin integrity.

Staff interview was conducted with the BP RPN where by the RPN said PCC was the only place a skin and wound assessment would be completed for the resident and the assessment was called a "Skin/Wound Assessment". The RPN said a skin and wound assessment should have been completed weekly in PointClickCare. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Staff interview was conducted with the Best Practice (BP) RPN on a specific date and time. The BP RPN said the altered skin integrity for an identified resident was first noted on a specific date, and was closed by a specific date.

Record review of the "Skin/Wound Assessments" completed in PointClickCare indicated the altered skin integrity was not assessed weekly on twelve occasions.

Staff interview was conducted with the Best Practice RPN on a specific date and time. The RPN said a skin and wound assessment should have been completed weekly in PointClickCare. [s. 50. (2) (b) (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 resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

On a specific date and time, an identified resident was observed being assisted with eating and drinking in their room and was not at a safe feeding position. The personal support worker stood at bed side and was above the resident's eye level to provide the resident with the main entree and juice. The resident's bed was also at approximately a 45 degree angle and not in an upright position, placing the resident at risk of choking. The personal support worker indicated they were aware they should have been sitting at the resident's eye level while assisting residents to eat and drink but said that the resident usually did not eat in their room and did not get a stool to do so.

Record review of the current care plan for the resident directed staff to position the resident at 90 degree angle and ensure the resident remains up for a specific period of time after meals and snacks, related to eating.

The Registered Dietitian indicated that the expectation was that staff should position the resident safely while being assisted with eating so that they were not placed at risk of aspiration. [s. 73. (1) 10.]

***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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the results of the investigation related to the suspected financial abuse was reported to the Director.

The licensee submitted a critical incident report to the Ministry of Health and Long-term Care to inform the Director of suspected financial abuse of an identified resident.

Interview with the CEO and Director of Care on June 14, 2016, indicated that the results of the investigation outcome was not reported to the Director related to the suspected financial abuse of the resident and the expectation would be that an amendment should have been completed by the home and submitted to the Director. Additionally, a record review of the Long-Term Care Homes Critical Incident System showed that the home failed to submit to the Director the outcome of the home's investigation related to the suspected financial abuse of the resident.

The licensee had failed to inform the Director in writing the results of the home's investigation of the suspected financial abuse of the resident. [s. 23. (2)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was bathed by the method of their choice.

Record review of the most recent care plan indicated that an identified resident preferred a bath and relied on staff for their personal care needs.

Interview with the resident indicated that the resident was currently receiving a bath two times a week, but shared that they would prefer to have a shower. The resident shared that when they requested a shower the staff stated that because of the resident's physical diagnosis a bath would be given instead.

Staff interview with a Registered Practical Nurse (RPN) agreed that there was no reason that the resident should not be able to have a shower if that was their preference, regardless of the resident's physical diagnosis. The Director of Care said that shower chairs were available in the spa room and that a resident should be showered if that is their preference. [s. 33. (1)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

Record review under the "Weights/vitals" tab in PointClickCare indicated that resident heights were not always measured on an annual basis.

Record review of the "Resident Weight Record / Monitoring" Policy # N-1K-41 last reviewed April 2016 stated, "Resident weights will be taken on admission and at least monthly unless otherwise directed." This policy did not account for the documentation of an annual height measurement.

Staff interview was conducted with the Director of Care (DOC) on June 15, 2016. The DOC said that the home had not been measuring heights on an annual basis and should be and that the home was in the process of changing their policy. [s. 68. (2) (e) (ii)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

**Specifically failed to comply with the following:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a process to report and locate residents' personal items.

Interview with an identified resident where by the resident described two personal items that went missing 3-4 weeks ago, a week apart. When asked if the resident reported the missing property to staff, the resident replied, "yes." The resident told the staff but they did not know anything about the personal items and the items were still missing.

Record review of the resident's progress notes indicated the resident reported the missing personal item and that the ADOC spoke directly with the resident about the item.

Staff interviews were conducted with two Personal Support Workers on specific dates and times. One PSW said that the resident had lost a personal item but that it was found in laundry and returned to the resident. Both staff were unaware of a missing second item.

Interview with a second identified resident where by the resident said one personal item was lost in the tub room a few weeks ago when the item was taken off. When asked if the resident reported the missing property to staff, the resident replied, "yes." The

resident asked many staff if they had seen the missing item and staff replied no. The resident said they meant to go to lost and found and did not, and the item was still missing.

Record review of the resident's progress notes indicated that the resident stated that the personal item was missing and that the bath staff noted them to be missing.

Staff interview was conducted with a PSW on a specific date and time. The PSW said they could not recall a complaint regarding a missing item for the resident and that if a resident did report missing property, they would report it to the RPN/RN in charge and explained they did not know where the information goes after that.

Staff interview was conducted with a Registered Nurse (RN) on a specific date and time. The RN said that a search for the missing property would occur discreetly and with the resident's permission, family or POA would be notified to see if it was taken home with them and to inform them of the missing item, and then if the item remained missing it would be reported to the DOC. The RN said she was not aware of any missing personal property for the identified resident.

Staff interviews were conducted with the CEO and ADOC on a specific date and time. The ADOC said that complaints of missing property would be noted on a progress note and documented in the communication binder. The ADOC was aware of only one missing personal item for the first resident and said that the resident's family was called and one item was taken home, but was unaware of the second missing item. The ADOC was unaware of the missing property belonging to the second resident.

Staff interview was conducted with the ADOC on another day. The ADOC said that there was no policy, procedure or tracking sheet for missing personal property, only for missing laundry. Staff interview with the CEO on June 9, 2016, said there was no policy in place to locate missing property, the only written documentation was in the Resident/Family Handbook on page 42 which stated, “Valuables – Saint Luke’s Place is not responsible for lost or damaged valuables including hearing aides, dentures, eye glasses or equipment such as wheelchairs, walker or seating cushions. You are strongly encouraged to procure your own insurance coverage for your valuables”. Also on page 45 which stated, “All other lost and found items (non-clothing) should be reported to the Registered Nurse. Saint Luke’s Place assumes no responsibility for lost or missing personal items”.

Staff interview was conducted with the DOC on June 15, 2016. The DOC said that the home does not have a policy or procedure in place for locating resident missing property, but the home used to have a form in place for missing personal items several years ago. [s. 89. (1) (a)]

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**Issued on this 18th day of July, 2016**

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

**Original report signed by the inspector.**