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
May 19, 2017	2017_419658_0002	005710-17	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

NEIL KIKUTA (658), ADAM CANN (634), MELANIE NORTHEY (563)

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): March 20, 21, 22, 23, 24, 28, 29, 30, and 31, 2017.

The following intakes were completed within this Resident Quality Inspection:
Critical Incident log #018236-16, CIS #C568-000011-16, related to alleged neglect;
Critical Incident log #019317-17, CIS #C568-000015-16, related to alleged abuse;
Critical Incident log #024180-16, CIS #C568-000016-16, related to a fall and significant change;
Critical Incident log #029271-16, CIS #C568-000020-16, related to a fall and significant change; and
Critical Incident log #032692-16, CIS #C568-000022-16, related to a fall and significant change.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Care, two Associate Directors of Care, four Registered Nurses, 15 Registered Practical Nurses, 15 Personal Support Workers, three Dietary Aides, one Recreation staff, three family members, the Family Council and Residents' Council Representatives, and over 40 residents.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
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
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident.

Record review of the current care plan for an identified resident had no documentation for the use of a mechanism on the resident's assistive device, or the use of a personal support when the mechanism was in use.

Record review of a progress note on a specified date, stated a care conference was held and family voiced a concern that staff needed to be mindful when the identified resident utilized the mechanism on their assistive device.

On three specified dates, an identified resident was observed in the resident's room and in the hallway in their assistive device with the mechanism in use.

On a specified date, an identified RPN shared that the mechanism was used for an identified resident for comfort and positioning. The RPN acknowledged that the planned care related to the use of the mechanism was absent from the care plan and there were no goals or interventions related to the use of these supports in the identified resident's plan of care. The RPN also acknowledged that PSW staff would not know if the mechanism was to be used since clear direction to the PSW staff was also absent from the kardex in PointClickCare.

The licensee failed to ensure that there was a written plan of care for an identified resident that set out the planned care, the goals the care was intended to achieve and clear directions to the PSW staff and others who provided direct care to the resident related to the use of the mechanism and supportive devices for the resident.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN and VPC being issued in inspection report #2015_226192_0047. [s. 6. (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 there is a written plan of care for each resident that sets out the planned care for the resident, the goals the care is intended to achieve, and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Record review of a Critical Incident System (CIS) Report submitted to the Ministry of Health and Long-Term Care on a specified date, reported that an identified resident noticed their appliance was dry at around 1500 hours on a specified date. The identified resident told the Registered Practical Nurse (RPN) that the appliance was dry and the RPN returned after 1800 hours to assess the resident. At that time the resident reported that abdominal "trouble" was just starting. A PSW notified the RPN and the RPN returned and told the resident that the Registered Nurse (RN) was notified. No one came until well after 2200 hours. The CIS report documented that the resident stated, "I'm not a complainer you know but this was so very painful. I was crying in pain."

Record review of the progress note in PointClickCare (PCC) on a specified date, at 2037 hours stated, “Resident complaints of being sore in the lower quadrant of the stomach. Stomach also feels hard. RN notified.” Progress note was written by an identified RPN.

Record review of the progress note in PCC on a specified date at 0045 hours stated, “Resident received this shift in significant pain. Holding onto lower abdomen which was very distended.” Progress note was written by an identified RPN.

Record review of the progress note in PCC on a specified date at 0127 hours stated that an identified RN assessed the specified resident at approximately 2245 hours, and found the abdomen distended and the resident complaining of pain. With the assistance of the RPN, the two staff changed the appliance, and the identified residetn felt comfortable and was very thankful.

On a specified date, an identified RN said the RPN reported that on another specified date, the identified resident was comfortable, and had no voiced complaints of pain with no abdominal distention noted. The RN stated the appliance was not changed because it would have been traumatic for the resident and that the resident would be sent to hospital. The RN acknowledged that the identified resident was not sent to the hospital for an appliance change. The RN did not assess the resident, and acknowledged the resident was seen once by the RN exiting the dining room after the dinner meal and appeared comfortable. The RN stated that the resident should have been seen on the day shift and by the doctor who was in, and that the appliance should have been taken care of long before the evening shift.

During a telephone interview on a specified date, the identified RPN stated that they had worked the evening shift of an identified date. The RPN stated the resident was first approached about the appliance at approximately 1630 hours during the first medication pass and told the resident that an assessment would take place after the dinner meal. The RPN assessed the appliance at 1830 hours. The RPN then spoke to the identified RN and returned to the resident at approximately 2000 hours to again reassess the appliance. The RPN said that the identified RN was approached three or four times and no help was received from the RN.

On a specified date, the identified resident stated, "the nurse came in and was very nasty to me." The identified resident said that the nurse was trying to fix the appliance and was leaning on the left “bad” leg and hurting it. The resident stated that the RPN said "move

your leg, get over" and the resident replied, "I can't its painful." The resident said the other nurse came later that night and was wonderful, the resident was crying and the nurse changed the catheter. "They really hurt me that night, I kept telling them "you're hurting me."

The licensee failed to ensure that an identified resident was not neglected by the licensee or staff related to the resident's appliance care. An identified RPN and RN changed the identified resident's appliance at the beginning of the night shift on a specified date, after the resident was found with abdomen distended and complaining of increased pain. The resident reported immediate relief once the appliance was changed.

The scope of this area of non-compliance was determined to be patterned. The severity was determined to be a level three, related to actual harm. There was a history of unrelated non-compliance in the last three years. [s. 19. (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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) 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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has 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.

Record review of the most recently completed "Continence Quarterly Assessment" in PointClickCare (PCC) on a specified date stated that an identified resident had urinary incontinence on a daily basis and was incontinent of bowels all or almost all of the time. The assessment did not include contributing factors affecting the resident's urinary or bowel function, the type of incontinence, and the potential to restore function with specific interventions.

Record review of the Minimum Data Set (MDS) Assessment on a specified date, stated that the identified resident was occasionally incontinent of bowel once a week and occasionally incontinent of bladder two or more times a week but not daily.

On a specified date, the Best Practice Resource- Registered Practical Nurse (RPN), shared that the "Continence Quarterly Assessment" was completed for all residents at the time of their MDS. The RPN acknowledged that the quarterly continence assessment did not include the identification of causal factors, type of incontinence and potential to restore function with specific interventions.

The licensee failed to ensure that the identified resident received an assessment that included identification of causal factors, patterns, type of incontinence and the potential to restore function with specific interventions.

The scope of this area of non-compliance was determined to be widespread. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of unrelated non-compliance in the last three years. [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 to ensure that each 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, to be implemented voluntarily.

Issued on this 30th day of May, 2017

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

Original report signed by the inspector.