Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 6, 2019	2019_739694_0012	002184-18, 009142-18, 014722-18, 020267-18, 020440-18, 022595-18, 033192-18, 009282-19, 012324-19	Critical Incident System

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

AMANDA COULTER (694), MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 11, 12, 15, 16 and 17, 2019.

Log #002184-18, related to responsive behaviours;
Log #020267-18, Log #022595-18, Log #033192-18 and Log#009282-19, related to falls with injury;
Log #020440-18, related to personal support services.

This inspection was conducted concurrently with a complaint inspection, 2019_739694_0013.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Administrator, Interim Director of Nursing (DON), Executive Assistant, Associate DON, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor (FSS) and residents.

During the course of the inspection, the inspectors toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, and the procedure was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(2), the licensee was to ensure that when a resident had fallen, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Specifically, staff did not comply with the licensee's policy, "Falls Prevention and Management",which stated, "the program must, at a minimum provide assessment when a resident has fallen, and post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls. Saint Luke's Place will use a comprehensive post fall assessment to examine in-depth risk areas related to falls, such as drug regimes, restorative care approaches and use of equipment, supplies, devices and assistive aids". Also, staff did not comply with the licensee's policy, "Post Fall Investigation - Fall Huddles", which stated "the team must complete the Assessment Tool fully to determine why the fall occurred." Attached was the "Post Fall Huddle – Assessment Tool".

A) An anonymous complaint was submitted to the Ministry of Long-Term Care (MOLTC), related to an incident where a resident sustained a fall with injury in August 2018, requiring transfer to hospital for assessment.

B) A resident had a fall in December 2018, and the resident sustained an injury which required the resident be transferred to the hospital for further medical treatment and

assessment.

C) A resident had a fall that occurred in May 2019, and the resident sustained injuries which required the resident be transferred to the hospital for further medical treatment and assessment.

D) A resident had a fall that occurred in August 2018, and the resident sustained injuries which required the resident be transferred to the hospital for further medical treatment.

In the case of the four identified falls, registered staff documented a post fall note outlining details of the fall, assessment and immediate treatment. This note did not include an analysis of the fall including contributing factors.

During an interview, staff said the Post Fall Huddle Assessment tool had been developed approximately two years ago but had not been implemented. Post fall assessments were not being conducted using a clinically appropriate assessment instrument specifically designed for falls.

There was no documented evidence that a "Post fall huddle - Assessment Tool" was completed for the identified falls.

The licensee failed to ensure that the falls prevention and management policy, as well as their post fall investigation policy, were complied with in relation to using a clinically appropriate assessment instrument specifically designed for falls when residents had fallen. [s. 8. (1) (a),s. 8. (1) (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 licensee institute or otherwise put in place any procedure, and the procedure is complied with, specifically when a resident has fallen, a post-fall assessment will be conducted using a clinically appropriate assessment instrument, specifically designed for falls,, to be implemented voluntarily.

Issued on this 13th day of August, 2019

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

Original report signed by the inspector.