Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 11, 2020	2019_610633_0018	021036-19, 021310-19	Complaint

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

SHERRI COOK (633), DANIELA LUPU (758), MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 20-22, 25-29, December 2-6, 9-11, 13, 16-18, 2019.

The following intakes were inspected during this inspection:

Log #'s 021036-19\ IL-71688-CW and #021310-19 related to Whistle-blowing protection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Nursing & Personal Care (DONPC), the Director of Human Resources (DHR), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the scheduling coordinator, an administrative assistant, a union representative and a lawyer.

In addition, multiple records were reviewed during this inspection which included the plan of care for identified residents, the home's related policies, reference materials and training related to chemical restraints, multiple employee files, an external legal nurse investigation report, the home's investigation records and associated documentation, medication incident reports, associated documentation and policies, multiple HR policies, the home's prevention of abuse policy and training and additional related documentation. Multiple records in addition to staff and management interviews were also reviewed from inspection 2019_610633_0014.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2007, c. 8, s. 26 (5).
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 2007, c. 8, s. 26 (5).
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 2007, c. 8, s. 26 (5).
4. A staff member. 2007, c. 8, s. 26 (5).

Findings/Faits saillants :

The Licensee has failed to ensure that no person did anything that had the effect of discouraging a person from doing anything mentioned in clauses (1)(a) to (c).

LTCHA, 2007, 26(1)(a) to (c) states in part that no person shall retaliate against another person, whether by action or omission, or threaten to do so because anything has been disclosed to an inspector and/or Director concerning the care of a resident or the operation of a Long-Term Care home that the person advising believed ought to be reported to the Director. LTCHA, 2007, 26(2) states in part that dismissing, disciplining or suspending a staff member, or intimidating, coercing or harassing any person constituted retaliation.

In response to multiple anonymous complaints received by the Ministry of Long-Term Care (MLTC), inspection 2019_610633_0014 was initiated. The complainants alleged the neglect of specific resident care and concerns related to the home's medication management system. An inspection was completed and confirmed the complainants reported concerns to the Ministry.

Two identified staff members and multiple other staff reported specific actions by the home after the Ministry's inspection report which were related to speaking and providing information to the inspectors. Multiple staff reported fear of negative consequences in their workplace for speaking with inspectors and/or reporting their concerns to the Ministry regarding resident care and the operations of the home.

Substantial information was gathered during this inspection which showed that actions of the licensee, through the home's management, towards two identified staff members and others, had the effect of discouraging multiple staff members to provide information to inspectors and the Director of the MLTC where the provision of the information was required or permitted by the Act or the regulations.

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 no person retaliates against another person, whether by action or omission, or threaten to do so because of anything has been disclosed to an Inspector or Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the home’s restraint policy complied with the requirements of the LTCHA and regulations regarding chemical restraints.

A letter incorrectly cited the criteria from the LTCHA and the home’s process that was allegedly not followed.

The home’s policy was provided as the home's policy in use. The home's policy did not include a correct definition, incorrectly cited the LTCHA and legislation, and was unclear related to a drug used under common-law duty. The home's policy also did not include a process for staff to follow regarding an actual chemical restraint.

Multiple staff had varying answers regarding a drug as a treatment versus a chemical restraint despite the home's training. Multiple staff said that the home did not have a clear process or policy in place.

The DONPC acknowledged a drug was not a physical restraint. The DONPC confirmed that the correct requirements under the LTCHA were not included. The DONPC agreed that there was no process contained in the home's restraint policy for staff to follow regarding a chemical restraint.

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’s restraint policy complies with the requirements of the LTCHA and regulations related to chemical restraints, to be implemented voluntarily.

Issued on this 18th day of March, 2020

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

Original report signed by the inspector.