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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 3, 2020	2020_773155_0006	003335-20	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

SHARON PERRY (155), SARAH INGLIS (767)

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): Offsite May 14, 15, 19, 21, 22, 27, 28, June 1, 3, 4, 12, 15, and 22, 2020. Onsite on June 10 and 11, 2020.

During this inspection log 003335-20 a complaint regarding pain management was inspected.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Administrator, Director of Nursing and Personal Care, Registered Nurse and other staff members.

The inspectors also toured E-wing, Main wing and lower Main resident living areas, reviewed relevant clinical records, policies and procedures, schedules, the home's investigation notes; and observed resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance

with the directions for the use specified by the prescriber.

On an identified date, resident #004 was ordered a medication to be administered every two hours when necessary (prn) for a specific intervention by the physician.

Review of the electronic Medication Administration Record (eMAR) showed that resident #004 was administered the medication on seven different occasions for use that was not specified by the prescriber.

Review of the progress notes for these times did not show that resident #004 was needing the medication as prescribed by the prescriber.

Staff member #106 who administered the medication on at least one occasion said that they administered the medication for a reason other than as prescribed by the prescriber.

Staff member #108 who administered the medication on more than one occasion said that they administered the medication for a reason other than as prescribed by the prescriber. They shared that RN #107 had directed them to administer the medication regularly for a reason other than as prescribed by the prescriber.

2. Resident #001 was ordered a medication to be administered every two hours when necessary (prn) for a specific intervention by the physician.

Review of the electronic Medication Administration Record (eMAR) for a two month period of time, showed that resident #001 was administered the medication on eleven different occasions for a reason other than prescribed by the prescriber.

Review of the progress notes for these times did not show that resident #001 was needing the medication as prescribed by the prescriber.

Staff member #109 shared that they gave the medication for reasons other than prescribed by the prescriber. They also shared that Management had directed them to administer the medications regularly.

RN #107 shared that they administered the medication to resident #001 on two different occasions for reasons other than prescribed by the prescriber. They stated that the medication should be given even it was for a reason not as prescribed by the prescriber.

Director of Nursing and Personal Care #101 shared that sometimes prn medications prescribed for a specific reason by the prescriber were administered regularly for reasons other than prescribed by the prescriber.

The licensee failed to ensure that medications were administered to resident #001 and #004 in accordance with the directions for use set out by the physician. [s. 131. (2)]

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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #003's pain was not relieved by initial interventions, resident #003 was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #003 was prescribed a medication for pain. On an identified date, resident #003's progress notes stated that the team was questioning if resident #003 was experiencing increased pain and a call was placed to the physician to discuss pain control. The physician ordered pain medication to be given prn (when necessary).

On an identified date resident #003's pain level was recorded as six on a ten point scale. Four days later, resident #003 refused their pain medication and their pain level was recorded as a seven. On the same date at a later time the pain medication was administered for a pain level of seven and was documented to be ineffective.

Resident #003's pain level for an identified six days, was recorded at times as zero, two, three, five, six and nine. During this time the prn medication was given on five occasions. It was noted that the medication was ineffective three of the five times.

Review of the homes Pain Management policy, Policy # N-M-01 revised December 2018, stated that the interdisciplinary team was to conduct a pain assessment utilizing a clinically appropriate instrument (Pain Assessment Tool) when the resident exhibits a change in health status or pain was not relieved by initial interventions.

Staff members #104, #105, #106 and Director of Nursing and Personal Care #101 shared that pain assessments were to be completed when a resident had a change in their pain medication and when the resident's pain was not relieved.

Staff member #104 shared that there were no pain assessments completed for resident #003 when they had a change in their pain medication or when they had pain that was not relieved.

The licensee failed to ensure that when resident #003's pain was not relieved by initial interventions, resident #003 was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 when a resident's pain is not relieved by initial intervention the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 6th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SHARON PERRY (155), SARAH INGLIS (767)
Inspection No. / No de l’inspection :	2020_773155_0006
Log No. / No de registre :	003335-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 3, 2020
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 :	Maureen Toth

To Saint Luke's Place, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.131(2).

Specifically, the licensee must ensure that:

1) PRN medications are administered as prescribed by the prescriber.

2) Training is provided to all registered staff regarding medications that are to be administered on an as needed basis (PRN) as prescribed by the physician. Training shall include the importance of documenting an assessment in relation to why the PRN medications are being administered.

3) Training is provided all registered staff regarding the licensee's policies entitled Palliative Pain Medication, Policy # N-S-05; End of Life Medical Directives, Policy # N-S-06; and Pain Management, Policy # N-M-01.

4) A record is kept of the training and that record must be accessible in the home.

5) An auditing process/tool to monitor that PRN medications are administered as prescribed is developed and implemented. A record of this is to be kept and that record must be accessible in the home.

Grounds / Motifs :

1. On an identified date, resident #004 was ordered a medication to be administered every two hours when necessary (prn) for a specific intervention by the physician.

Review of the electronic Medication Administration Record (eMAR) showed that resident #004 was administered the medication on seven different occasions for use that was not specified by the prescriber.

Review of the progress notes for those times did not show that resident #004 was needing the medication as prescribed by the prescriber.

Staff member #106 who administered the medication on at least one occasion said that they administered the medication for a reason other than as prescribed by the prescriber.

Staff member #108 who administered the medication on more than one occasion said that they administered the medication for a reason other than as prescribed by the prescriber. They shared that RN #107 had directed them to administer the medication regularly for a reason other than as prescribed by the prescriber.

2. Resident #001 was ordered a medication to be administered every two hours when necessary (prn) for a specific intervention by the physician.

Review of the electronic Medication Administration Record (eMAR) for a two month period of time, showed that resident #001 was administered the medication on eleven different occasions for a reason other than prescribed by the prescriber.

Review of the progress notes for these times did not show that resident #001 was needing the medication as prescribed by the prescriber.

Staff member #109 shared that they gave the medication for reasons other than prescribed by the prescriber. They also shared that Management had directed them to administer the medications regularly.

RN #107 shared that they administered the medication to resident #001 on two different occasions for reasons other than prescribed by the prescriber. They stated that the medication should be given even it was for a reason not as prescribed by the prescriber.

Director of Nursing and Personal Care #101 shared that sometimes prn medications prescribed for a specific reason by the prescriber were administered regularly for reasons other than prescribed by the prescriber.

The licensee failed to ensure that medications were administered to resident #001 and #004 in accordance with the directions for use set out by the physician.

The severity of this issue was determined to be level 2 minimal harm/risk. The scope of this issue was determined to be level 2, pattern. The compliance history was determined to be level 3, previous non-compliance to the same subsection that included:
-compliance order (CO) #001 issued October 18, 2019, with a compliance due date of November 29, 2019 (2019_610633_0014). (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 17, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY

Service Area Office /
Bureau régional de services : Central West Service Area Office