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
Dec 15, 2020	2020_738753_0027	020922-20	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

KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)

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): November 16-20, 23-24, 2020

The following Critical Incident System (CIS) intakes were inspected during this CIS inspection:
Log #020922-20 related to fall prevention and management.

This Critical Incident inspection was completed concurrently with Complaint inspection # 2020_800532_0026.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Falls Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Residents, and Personal Support Workers (PSW).

The inspectors also observed resident and staff interactions, reviewed clinical health records, and other pertinent documents.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was reassessed and fall prevention interventions were not effective, that different approaches were considered in the revision of the plan of care.

A resident sustained an unwitnessed fall that resulted in a significant injury.

The resident was considered at high risk for falls. Staff were directed to ensure fall prevention interventions were in place.

Despite the resident falling frequently resulting in various injuries, fall prevention interventions had not been modified in several months.

Additional fall prevention interventions were requested by staff, but they were not implemented.

Different approaches were not considered in the revision of the plan of care for several months when the resident continued to experience falls, one of which lead to a significant injury.

Sources: Critical Incident System Report, Risk Management, Resident Care Plan, Assessments, and interviews with the Falls Lead and other staff [s. 6. (11) (b)]

2. The licensee has failed to ensure that when a resident was reassessed and fall prevention interventions were not effective, that different approaches were considered in the revision of the plan of care.

A resident was considered at high risk for falls. The resident's falls history included falls with significant injuries. Staff were directed to ensure fall prevention interventions were in place.

Despite the resident falling frequently resulting in various injuries, fall prevention interventions had not been modified for an extensive amount of time.

Different approaches were not considered in the revision of the plan of care despite the resident continuing to experience falls. This put the resident at risk for another fall with a significant injury.

Sources: Risk Management, Resident Care Plan, Assessments, and interviews with the resident and staff [s. 6. (11) (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 when a resident is reassessed because fall prevention interventions are not effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 4th day of January, 2021

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

Original report signed by the inspector.