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
Jun 18, 2021	2021_792659_0013	006472-21, 007107-21	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

JANETM EVANS (659), KATHERINE ADAMSKI (753)

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): May 11, 12, 13, 14, 17, 18, 19, 20 and 21, 2021.

The following intakes were completed during this inspection:
Log #007107-21\ Complaint related to a resident fall with injury and staffing.
Log #006472-21\ Critical Incident System (CIS) related to a resident fall with injury.

PLEASE NOTE: Written Notifications and Compliance Orders related to LTCHA, 2011, s. 24 (1) and O. Reg. 79/10, s. 229 (4), were identified in this inspection, and have been issued in Inspection Report #2021_738753_0012, dated June 18, 2021, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Nursing/Infection Prevention and Control Lead (ADON/IPAC Lead), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), IPAC team members, Region of Waterloo Public Health Inspector and residents.

Observations were completed of IPAC practices, staff to resident interactions, and general care and cleanliness. A review of clinical records including but not limited to care plans, progress notes, assessments, risk management tools and relevant policies and procedures was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Reporting and Complaints

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff implemented safe transferring techniques for a resident.

A resident required extensive assistance from two staff for activities of daily living (ADL).

One staff member provided ADL assistance to the resident without a second staff member present. The resident fell and sustained an injury.

The resident was transferred to hospital for further assessment and provided treatment.

The staff member acknowledged they provided care to the resident without the assistance of a second staff member, and as a result the resident fell and sustained an injury.

Sources: CIS report, resident's plan of care including progress notes and care plan, the long term care home's investigative notes, interviews with the DOC and other staff. [s. 753]

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 staff use safe transfer techniques when assisting residents, to be implemented voluntarily.

Issued on this 29th day of June, 2021

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

Original report signed by the inspector.