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
Feb 3, 2022	2022_962753_0002	000968-22	Proactive Compliance Inspection

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 Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 17-21, 24-28, 2022.

Log #000968-22 was completed related to this Proactive Compliance Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant DOC, Maintenance and Facility Manager, Food Services Manager, Wellness Manager, Best Practice Registered Practical Nurse (RPN), Registered Nurses (RN), RPN's, Residents, Personal Support Workers (PSW), Housekeeping, and Surveillance Staff.

Observations were made of dining and snack service, infection prevention and control practices, medication administration, and staff to resident interactions. A review of documentation was completed including but not limited to programs, policies and procedures, medication incidents and relevant clinical records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal walkers and wheelchairs were cleaned as required in the home.

Walkers and wheelchairs were covered with dried food particles, food crumbs, skin particles, hair, mud, and dust.

Additionally, a resident stated that the cushion on their wheelchair had not been changed in months, despite it being dirty.

Staff had documented that the mobility aides had been cleaned as recently as the day prior to the observations.

A Personal Support Worker (PSW) stated that wheelchairs and walkers had not been cleaned for a long time in the entire home. The Director of Care (DOC) acknowledged that the equipment had not been cleaned, therefore staff should not have documented that they had cleaned the equipment.

A safe and clean environment was not provided to the resident's when their mobility aides were not cleaned as required.

Sources: Observations of resident's wheelchairs and walkers, interviews with residents, the DOC and other staff, Cleaning Schedule. [s. 37. (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 personal walkers and wheelchairs are cleaned as required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that dining and snack service included a review of the meal and snack times by the resident's council.

A resident stated that they didn't think that there was a review of the meal and snack times by the Residents' Council or the Food Committee.

The Food Services Manager did not review meal and snack times as they were not aware of the legislation.

Sources: Interviews with a resident and the Food Service Manager, Residents' Council meeting minutes. [s. 73. (1) 2.]

2. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance, and encouragement required to safely eat and drink as comfortably and independently as possible.

The following was observed from January 17 to 20, 2022:

a) Resident #005 was assessed at high nutrition risk, they required assistive aides and intermittent assistance from staff.

Resident #005 was served their meal on a paper plate and cup, they had physical difficulty getting the food to their mouth. The food was falling off the paper plate and there was no assistance provided to the resident.

Resident #005 was not pleased with the plastic cutlery and complained of the paper plates being fragile.

A Registered Practical Nurse (RPN) stated that resident #005 did not require assistance because they were independent with feeding, and if the food falls off the paper plate, staff pushed it back onto the plate.

b) Resident #006 was assessed at high nutrition risk, they required supervision, encouragement and limited to total assistance with eating and drinking.

Resident #006 was served their meal however, they did not eat or touch the food on their plate. There was no assistance provided to resident #006 and the food sat in front of them for over 40 minutes.

Three staff stated that they were aware that the residents required support and assistance, but they were busy with serving other residents in their rooms and had no extra help to support the residents that required assistance.

A RPN had notified the DOC regarding the shortage of staff and the residents receiving cold meals due to lack of staff available to feed. When residents did not receive the appropriate assistive devices or assistance with feeding, it put the residents at risk of dehydration and malnutrition.

Sources: Observations and plan of care for #005 and #006, interviews with residents, the DOC and other staff, and an email from a staff to the DOC. [s. 73. (1) 9.]

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 dining and snack service includes a review of the meal and snack times by the Residents' Council, and that residents are provided with any eating aids, assistive devices, personal assistance, and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that was to be destroyed and disposed of was to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The home's Medication Destruction policy did not include that any controlled substance that was to be destroyed and disposed of was to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

A discontinued controlled substance card was sitting behind the controlled substances that were available for administration and ready to be picked up. An RPN said that the card could stay on the cart for 24 hours or longer until it was removed.

The Health and Wellness Manager acknowledged that the controlled substance that was discontinued stayed on the medication cart behind the controlled substance that was available for administration until it was picked up by one of the managers. They stated that the homes policy did not include that controlled substances that were to be destroyed and disposed of were to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration.

Sources: Observations of medication administration and storage, the home Medication Destruction Policy (#N-R-09), interviews with the Health and Wellness Manager and other staff. [s. 136. (2) 2.]

2. The licensee has failed to ensure that the home's drug destruction and disposal policy included that drugs were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The home's Medication Destruction policy did not include that drugs were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices.

The Health and Wellness Manager reviewed both the homes’ and pharmacies drug destruction polices and acknowledged that neither included that drugs were to be destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Sources: the home's Medication Destruction Policy (#N-R-09), interviews with the Health and Wellness Manager. [s. 136. (2) 3.]

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 drug destruction and disposal policy includes that any controlled substance that is to be destroyed and disposed of is to be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs and that drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program.

Best Practices for Hand Hygiene in All Health Care Settings, 4th edition dated April 2014, consideration with gloves:

"Several studies provide evidence that wearing gloves can help reduce transmission of pathogens in health care settings. However, gloves do not provide complete protection against hand contamination. The use of gloves does not replace the need for hand hygiene."

Observations and interviews conducted throughout the inspection, showed the following:

a) Multiple staff wore gloves to deliver meal trays from room to room.

Gloves were not removed or discarded after the meal trays were delivered to the residents and staff used the same gloves to touch the residents and the contaminated environment (i.e. opened doors, call bells, and assistive devices).

Staff were also using gloves to remove the meal trays from the resident’s rooms and wore the same gloves across the hallway and assisted the residents with the activities of daily living.

b)Two resident rooms had droplet-contact precaution signage posted on their entry doors. Two PSW's and one RPN did not wear personal protective equipment when assisting the the residents with their meal trays and medication.

Staff stated that they wore gloves for the delivery and the pick-up of the trays and acknowledged that they did not change the gloves or discard them until after the service was done.

Staff members also stated that they were not aware of the reason for the droplet-contact precaution signage on the doors.

The IPAC Lead stated that the staff were not supposed to wear the gloves from room to room and the communication was sent out to staff regarding the outbreak on a regular basis.

When staff did not implement the home's IPAC program, this increased the risk of infectious disease transmission throughout the home.

Sources: Observations, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition dated April 2014, interviews with the IPAC Lead and other staff. [s. 229. (4)]

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 participate in the implementation of the home's IPAC program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident, who required continence care products, had sufficient changes to remain clean, dry and comfortable.

The home's Continence Care and Bowel Management policy documented that individualized continence care plans would be developed for each resident to maximize independence, comfort and dignity, based on resident preferences and assessed needs.

The procedure documented that the home was to ensure that resident’s plan of care considered their choices and preferences and that residents were to be provided with a range of continence care products that promoted their comfort and dignity. It was the responsibility of the multidisciplinary team to support residents with their comfort.

A resident was incontinent requiring a continence product. When the resident required a change, they often had to wait a long time for staff to assist them, they were told that their brief was not soiled enough for a change, or that the brief they were wearing was good for another four hours.

A PSW stated that, at times staff did conserve briefs if they felt that the briefs were not soiled enough with urine. They also stated that depending on how full the brief was or what it was soiled with, residents may only receive peri-care and that the same brief would be re-applied.

The home’s Best Practice Registered Practical Nurse (RPN) stated that the expectation was that if a brief was taken off, it should not be reused.

When staff did not respect a resident's preference related to continence care, the resident did not feel clean, dry and comfortable.

Sources: Interviews with a resident, the home's Best Practice RPN and other staff, the home's Continence Care and Bowel Management Program policy (#N-O-01). [s. 51. (2) (g)]

Issued on this 4th day of February, 2022

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

Original report signed by the inspector.