Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Amended Public Report (A2)

Report Issue Date: January 17, 2023

Inspection Number: 2022-1509-0001

Inspection Type:
Critical Incident System

Licensee: Saint Luke's Place

Long Term Care Home and City: Saint Luke's Place, Cambridge

Lead Inspector	**Inspector Digital Signature**
Betty Jean Hendricken (740884)	Elizabeth J Hendricken Digitally signed by Elizabeth J Hendricken Date: 2023.01.23 10:02:36 -05'00'

Additional Inspector(s)
Stephanie Smith (740738)
Farah Khan (695) was present during this inspection

AMENDED INSPECTION REPORT SUMMARY

This Licensee Report has been revised to reflect an amended Compliance Due Date. The Critical Incident System Inspection was completed on December 19 to 21, 2022, and December 28, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 19 to 21, 2022, and December 28, 2022

The following intake(s) were inspected:

- Intake: #00001285-[CI: 3014-000027-21] - related to fall
- Intake: #00004625-[CI: 3014-000009-22] - related to unsafe transfer of a resident

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the Licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

Rationale and summary

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (last updated October 6, 2022) requires the licensee to ensure that all staff, students and volunteers wear a medical mask for the entire duration of their shift indoors.

i) A staff member was observed sitting in the activity area of E-Wing with their mask pulled below their chin. Several residents were sitting within six feet of the staff member. The staff member later verified that they should have moved away from the residents if they removed their mask.

ii) A staff member was cleaning the floor of A-Wing outside the dining room and was observed to have their mask pulled below their chin. Three residents were sitting nearby, within one foot of the staff member. When prompted by Inspector regarding their mask placement, the staff pulled their mask up.

Failure of staff to follow universal masking guidelines, put the residents at increased risk for infection.

Sources: Observations, staff interviews, the home's universal masking policy, Minister's Directive: COVID-19 response measures for long-term care homes updated August 30, 2022, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated October 6, 2022

[740738]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1)

The licensee has failed to ensure that the Director was immediately informed of an incident causing harm to a resident. The former Associate Director of Nursing and Personal Care (ADoNPC) had reasonable grounds to suspect improper or incompetent treatment or care of a resident.

Rationale and Summary:

A resident fell from a sling and was injured while being transferred by staff.

The Critical Incident was not immediately submitted to the Director. The former ADoNPC confirmed they did not report the incident immediately as required.

Sources: Critical Incident Reporting System; Interview with the former ADoNPC, resident's progress notes

[740884]

WRITTEN NOTIFICATION: Plan of Care

NC #3 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident related to transfer sling type and method of application.

Rationale and Summary

A resident fell from a sling during a transfer via mechanical lift, resulting in an injury. It was later determined that the straps on the sling were not applied as required by policy. According to one of the PSWs present during the incident, the two PSWs transferring the resident had differing opinions on how to apply the sling.

The resident's plan of care stated the resident required a mechanical lift for transfers. It did not indicate the type of sling to use or the method of application. There was also no transfer assessment in the resident's plan of care that provided clear direction related to sling type or method of application.

The Best Practice Nurse stated that there were two types of slings in the facility with different methods of application. The PSWs were to know the method of application based on the color of the sling, but the colour was not identified in the plan of care.

Failure of the home to ensure that clear directions were set out in the plan of care related to transfer sling type and method of application may have contributed to an adverse event for the resident.

Sources: Resident's clinical records, interview with former ADoNPC and other staff, CIS #3014-000009-22

[740884]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the Licensee must:

1. Review and revise the Patient Sling Lift Policy to include:

    a. The person(s) responsible for resident transfer assessments.

b. A description of the process for communicating a resident's transfer status to the team.

c. Where sling type and method of application will be identified/documented.

d. A description of slings used in the home and methods of application based on manufacturer's instructions.

2. Ensure staff are aware of sling types and methods of application for residents using a mechanical lift on a specified unit.

3. Educate staff impacted regarding their roles and responsibilities with completing and documenting transfer assessments.

4. Document the education including the date and person who provided the education.

Grounds:

The licensee has failed to ensure that staff used safe transferring techniques when transferring a resident.

Rationale and Summary

A resident fell out of the sling while being transferred by two PSWs, resulting in an injury. The home's investigation notes determined that the PSWs incorrectly applied the sling.

The policy titled, Arjo Maxi 500 and Medi SSL Patient Sling Lift did not provide clear direction on how and when a resident was assessed for transfers, who completed the assessment, the method of application for each sling and where the assessment should be documented. A Registered practical Nurse (RPN) was not aware of the process for assessing a resident for transfers and there was no documented transfer assessment for the resident. The physiotherapist stated they would determine if a resident required a mechanical lift but was not involved in determining sling size or type.

Failure of the home to ensure that staff utilized safe transferring techniques when transferring the resident, led to a fall resulting in an injury.

Sources: Interviews with the former ADoNPC and other staff, the LTCH's investigation notes, Policy #N-K-08 Arjo Maxi 500 and Medi SSL Patient Sling Lift and Critical Incident (CI) report 3014-000009-22

[740884]

This order must be complied with by March 2, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.