Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: April 19, 2023
Inspection Number: 2023-1509-0002
Inspection Type:
Follow up
Critical Incident System

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

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	

Additional Inspector(s)
Janet Groux (606)
Mark Molina (000684)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4-6 and 11-14, 2023

The following intake(s) were inspected:

- Intake: #00002531 - [CI: 3014-000018-22] - related to improper care of a resident
- Intake: #00004567 - [CI: 3014-000010-22] - related to responsive behaviours of a resident resulting in injury
- Intake: #00017390 - [CI: 3014-000002-23] - related to a fall of a resident resulting in injury
- Intake: #00017657 - Follow-up #: 1 - O. Reg. 79/10 - s. 36

The following intake(s) were completed in this inspection:

- Intake: #00005956 - [CI: 3014-000007-22] - related to a fall of a resident resulting in injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1509-0001 related to O. Reg. 79/10, s. 36 inspected by Alicia Campbell (741126)

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

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Responsive Behaviours
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident’s plan of care was revised when the resident’s care needs changed, and the care set out in the plan of care was no longer necessary.

A resident’s care plan indicated that the resident used a specific assistive device for ambulation. This assistive device was not observed in the resident’s room. Staff indicated that the resident used a different assistive device for ambulation.

The resident’s care plan was updated to reflect the residents’ current needs for ambulation.

Sources: Observations of resident and resident’s room; resident’s care plan; interviews with staff.

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Date Remedy Implemented: April 13, 2023

[741126]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On April 5, 2023, two observations showed that the storage room door on unit A second in the home was open.

Staff acknowledged that this door must be closed and locked. Subsequent observations of the storage room door on unit A second showed that it was closed and locked.

Sources: Inspector #741126's observations, interview with staff.

Date Remedy Implemented: April 11, 2023

[741126]

WRITTEN NOTIFICATION: Medication Administration

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

Rationale and Summary

The licensee has failed to ensure that drugs administered to a resident were in accordance with the directions for use specified by the prescriber.

A resident was complaining of pain in a specified area. To relieve the pain, the resident was provided a medication that was specified to be administered for pain in a different location.

A Registered Nurse stated that the medication was not administered in accordance with the directions for use specified by the physician.

There was potential for an adverse medication reaction because the resident was provided a medication that was not in accordance with the directions for use specified by the prescriber.

Sources: Interviews with staff, resident's progress notes, resident MAR administration report.

[000684]