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

Original Public Report

Report Issue Date: December 6, 2023	
Inspection Number: 2023-1509-0004	
Inspection Type: Complaint Critical Incident (CI)	
Licensee: Saint Luke's Place	
Long Term Care Home and City: Saint Luke's Place, Cambridge	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.12.08 10:40:53 -05'00'
Additional Inspector(s) Megan Brodhagen (#000738) Gurvarinder Brar (#000687)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 14, 2023

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00088412, #00088626, #00089087, #00093511, #00094859 - related to Prevention of Abuse and Neglect

The following Complaint intake(s) were inspected:

- Intake: #00097313 - related to concerns with Palliative Care, Prevention of Abuse and Neglect

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical and verbal abuse by staff.

Section 2 (1) of the Ontario Regulation 246/22 (O. Reg. 246/22) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Section 2 (1) of the O. Reg. 246/22 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rational and Summary

A resident refused care. Despite this, a staff member forcefully provided care to the resident which resulted in the resident becoming injured. The staff member also communicated to the resident in an intimidating manner which upset the resident.

Sources: clinical records, the home's investigation notes, and interviews with the DOC and other staff. [#000687]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

Registered staff completed an initial skin and wound assessment for a resident's skin concern.

The registered staff did not complete a follow-up skin and wound assessment and/or document in the resident's progress notes that the skin concern had resolved.

The Clinical Care Coordinator (CCC) stated that registered staff were expected to complete a weekly skin and wound assessment on the skin concern until it had resolved.

When a resident's skin concern was not assessed as required, it increased the risk for potential complications.

Sources: clinical records, Skin and Wound Care Management Program Policy (December 2021), and interviews with the CCC and other staff. [#000738]

WRITTEN NOTIFICATION: Palliative Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (b)

The licensee failed to ensure that, based on the assessment of a resident's palliative care needs, the palliative care options made available to the resident included, at a minimum, symptom management.

Rationale and Summary

A resident required medications for symptom management. Staff did not administer the medication and responded inappropriately when more medication was requested.

The Palliative Care Lead stated that the response from staff was inappropriate and not consistent with the home's palliative care approach.

A resident's palliative symptoms were not managed when staff did not provide medication as required.

Sources: clinical records, the home's Palliative Care Policy (#N-S-01), interviews with resident's family, the Palliative Care Lead and other staff. [#753]