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
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: June 24, 2024
Inspection Number: 2024-1509-0003
Inspection Type: Complaint
Licensee: Saint Luke's Place
Long Term Care Home and City: Saint Luke's Place, Cambridge

Lead Inspector	**Inspector Digital Signature**
Mark Molina (000684)	Mark Molina Digitally signed by Mark Molina Date: 2024.06.25 09:40:56 -04'00'

Additional Inspector(s)
Jasneet Ahuja (000865)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27-30, 2024 and June 3, 2024

The following intake(s) were inspected:

- Intake: #00113504 - IL-0125019-CW Complaint with concerns re: medication management

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's plan of care related to disease management was implemented as per the physician's order.

Rationale and Summary
When a resident displayed worsening signs and symptoms of their disease, the physician was to be notified as per the physician's orders. The physician was not notified of a resident's worsening signs and symptoms of a disease on two occasions.

Failure to follow the care set out in the plan of care for a resident, put the resident at risk for complications of their disease.

Sources: Interview with staff, Resident's clinical notes, LTCH's investigation notes [000684]
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WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to ensure that a resident's glucometer was calibrated monthly.

In accordance with O. Reg 246/22 s. 123 (3)(a), the licensee is required to ensure that there is a medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Specifically, the licensee did not comply with their pharmacy's glucometer calibration policy which stated that calibration is to be done monthly to ensure glucometer accuracy.

Rationale and Summary
The home's pharmacy policy stated that glucometer calibration was to be done monthly. There was no documentation of calibration being completed for a resident for certain months.

Failure to comply with the monthly calibration policy may have decreased the accuracy of a resident's glucometer.

Sources: Home's glucometer calibration policy, Resident's clinical records, Interview with staff.
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