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

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Public Report

Report Issue Date: January 24, 2025
Inspection Number: 2025-1509-0001
Inspection Type: Critical Incident
Licensee: Saint Luke's Place
Long Term Care Home and City: Saint Luke's Place, Cambridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15 - 17, and 20 - 24, 2025

The following intake(s) were inspected:

- Intake: #00131683 - Abuse of a resident resulting in an injury
- Intake: #00135430 - Unexpected death of a resident

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

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

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)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from abuse by anyone when a co-resident struck them, resulting in an injury.

Sources: Progress notes, interviews with a PSW and DNPC.

WRITTEN NOTIFICATION: Skin and Wound Care program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment, using a clinically appropriate tool designed for that purpose.

The licensee failed to ensure that a resident had documented skin and wound

assessments for skin integrity issues that occurred between specified days in July and August 2024.

Sources: July and August 2024 eMAR and eTAR, progress notes, PCC assessment tab, interviews with an RPN and Skin and Wound lead.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that when a resident exhibited altered skin integrity a weekly assessment was completed for each wound.

A resident was documented to have eight wounds. Between October to December 2024, weekly assessments were not documented for each wound.

Sources: Progress notes, PCC weekly skin assessment, PCC skin and wound app, interview with Skin and Wound lead and the DNPC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that the home's staff took action and responded to the behavioural needs of a resident through interventions identified in the care plan when a resident struck another resident twice, resulting in injury.

Sources: Resident's BSO Tip book, progress notes, and care plan; interview with a PSW and BSO Lead.