Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2014	2014_240506_0022	H-001250-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

Long-Term Care Home/Foyer de soins de longue durée

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LESLEY EDWARDS (506), CYNTHIA DITOMASSO (528), JESSICA PALADINO (586), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 22, 23, 24, 25, 26, 29, 30 and October 1, 2014

This inspection was conducted concurrently with Follow-Up Inspections H-001262-14, H-001260-14, H-000559 and H-001260-14 and Critical Incident H-000382-14, H-000325-14, H-000813-14, H-000693-14 and H-001063-14 and Complaint Inspection H-000623-14 and H-000963-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Dietitian (RD), Recreation Supervisor, Resident Advisor, Director of Support Operations, registered staff, housekeeping staff, Maintenance Supervisor, dietary staff, Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents,reviewed resident health records, meeting minutes, policies and procedures, schedules, education records and complaint logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for resident #008 set out clear directions to staff and others who provide direct care to the resident.

Registered and non-registered staff interviewed on identified dates in September, 2014, confirmed that resident #008's oral care routine is to brush the resident's teeth upon waking and after dinner; however, review of the resident's documented plan of care stated that the resident will maintain good oral hygiene with assistance only. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

i. The plan of care for resident #104 identified that they were high risk for falls, and outlined a variety of fall prevention interventions. Review of the resident's fall incident notes included a fall on an identified date in March 2014, and one in August 2014, where the resident was not wearing their specific intervention the time of each fall. Interview with registered staff confirmed that the staff did not ensure the resident was wearing their specific intervention at the time of their falls in March and August 2014, as specified in the plan of care.

ii. Resident #007's plan of care directed staff to have the resident's specified intervention applied during the day to decrease the chance of injury in case of a fall. On an identified date in January, 2014, the health record indicated that the resident did not have their specific intervention applied because one was soiled and sent down to laundry and the other was lost. The resident fell the same day without the specific intervention in place. No injury was detected at that time or in the post fall assessments; however, a possible injury was diagnosed by X-ray on an identified date in January, 2014 and a confirmed injury by a CT scan on an identified date in February, 2014. This information was confirmed by the health record and the DOC. (506) [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure the home's policy related to wandering residents was complied with.

Record review revealed that resident #200 was reported missing from the home on an identified date in June, 2014. A staff member indicated that the resident was last seen at 1530 hours. The resident was found far away from the home and was brought back to the home at 1930 hours. The resident's plan of care stated that the resident is at risk of elopement and that the resident had eloped in the past. The home's policy "Risk Management And Safety – Care of Wandering Residents" (last revised December 19, 2013) stated that if the assessment of a resident indicated that the resident is identified as a wanderer, the staff are to check the location of the resident hourly. The resident was unaccounted for at the home from 1530 hours to 1700 hours, therefore was not monitored hourly and this was confirmed by the staff on September 30, 2014. [s. 8. (1)]

2. The licensee did not ensure that the policy and procedure for infection prevention and control: additional precautions was complied with.

The home's policy Infection Prevention and Control:Additional Precautions (policy number 4-03, last revised October 2011) stated the steps to be taken when initiating additional precautions, which include placing the appropriate sign on the resident's door, placing the appropriate personal protective equipment (PPE) at the resident's door way, notify the infection prevention and control representative, add the resident to the line list, and indicate this on the daily census.

i. From September 22 to 24, 2014, an isolation cart with PPE was noted at resident

#100's doorway; however, there was no sign on the door indicating what type of precautions to take when entering the room. Review of the plan of care indicated that the resident was on contact isolation precautions for an antibiotic resistive organism. Interview with registered and direct care staff confirmed that the contact isolation sign was not on the resident's door. [s. 8. (1) (b)]

3. The licensee did not ensure that the policy and procedure for sling care was complied with.

The home's Resident Care Manual policy for sling care (policy number 17-8, last revised December 2013) indicated that slings cannot be left under a resident, unless the resident has been assessed by a member of the safe client handling committee and the resident has been deemed appropriate to leave the sling under them. Once the resident has been deemed appropriate to have the sling left under them, this must be included in their plan of care and the resident's Substitute Decision Maker (SDM) must be informed of this. The SDM must also be informed that there is a risk of injury if the sling is left under the resident.

i. On an identified date September, 2014 eight residents were observed to have slings left under them. A review of the clinical record indicated that the residents were not assessed and deemed appropriate for this intervention. The SDM's were not informed and this was not added to the residents' plans of care. The DOC confirmed on an identified date in September, 2014 that the home was not following their policy and procedure for sling care. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that is, (e) available in every area accessible by residents in relation to the following:

On an identified date in September, 2014, during the initial tour of the home it was noted that four home areas had balconies that were not equipped with a communication response system. Staff and the Administrator interviewed confirmed that the balconies on the Birch, Cedar, Fir and Garland units are accessible to residents during the warmer months and confirmed that there was no call system available on the balconies. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every area accessible by residents is equipped with a communication response system, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date in September, 2014, during an initial tour of the home and concerns brought forth by two family members, the following was noted not to be in a good state of repair:

i. The carpet in resident #100's room was noted to be stained brown throughout the entrance into the room and extending to the area between the bedroom and bathroom. Interview with the Maintenance Supervisor confirmed that the resident's carpet needed to be removed.

ii. The commode in the shower room located on Garland home area was noted to be in a poor state of repair. The grey plastic seat was stained a brown/yellow colour and the metal on the chair legs was chipped. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The home has a monthly restraint flow sheet which registered staff are expected to sign each eight hour shift to indicate that they have reassessed the restraint.
i. Of three months of forms reviewed for resident #001, the following was revealed:
September 2014 - there were 22 shifts where the nurse failed to document;
August 2014 - there were 9 shifts where the nurse failed to document;
July 2014 - there were 12 shifts where the nurse failed to document;

This information was confirmed by the registered staff and the DOC.

ii. Monthly restraint flow sheets for resident #001 were not dated with the month and year as indicated on the form. [s. 30. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not ensure that advice related to concerns or recommendations received by the Residents' Council was responded to in writing within 10 days.

During an interview with the Residents' Council President and two council members on an identified date in September, 2014, the residents stated that concerns brought forward to the Food Service Supervisor related to meal service and particular menu items were never addressed or responded to. There was no record to indicate that the recommendations made by the council regarding dietary concerns were responded to in writing within ten days. This was confirmed by the Administrator. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not ensure that advice related to concerns or recommendations received by the Family Council was responded to in writing within 10 days.

Interview with two Family Council members revealed that not all concerns or recommendations were responded to in writing within 10 days. A review of the meeting minutes confirmed that concerns brought forward at the October, 2014 meeting were not responded to in writing by the Administrator until January 2014, and concerns that were brought forth at the May, 2014 meeting were not responded to in writing. This was confirmed by the Administrator. [s. 60. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

All residents' records revealed heights were not being taken annually as evidenced by review of the home's clinical records. This was confirmed by the ADOC. [s. 68. (2) (e) (ii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that home's meal and snack times were reviewed by the Residents' Council.

Interview with the Residents' Council President and two council members on an identified date in September, 2014 revealed that the home's meal and snack times had not been reviewed by the council. There was no record to indicate that the meal and snack times had been reviewed. The Council Assistant and Administrator confirmed this. [s. 73. (1) 2.]

2. The licensee did not ensure each resident was served course by course during meal service.

During dinner meal observation in the dining room on an identified date in September, 2014, five residents were given their dessert while they were still eating their entrees. [s. 73. (1) 8.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not ensure that the advice of the Family Council was sought out when developing and carrying out the satisfaction survey, and in acting on its results.

Interview with two Family Council members on an identified date in September, 2014 revealed that the council was not given the opportunity to participate in developing the home's satisfaction survey. During an interview on an identified date in September, 2014, the Administrator stated that the council's input is informally used in developing the survey throughout the year at each meeting; however, the council was not aware of this. The Administrator confirmed that the survey questions are not reviewed with the council for input prior to distribution in the home. [s. 85. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On identified dates in September, 2014, the wheelchair of resident #008 was observed to be dirty. Old food crumbs were noted on the seat of the chair, and covering the bottom base in and around the wheels. August and September 2014, Weekly Wheelchair Cleaning Schedule for the unit did not include regular documentation that wheelchairs were being cleaned. Interview with direct care staff on an identified date in September, 2014, confirmed that the wheelchair for resident #008 was not kept clean. [s. 87. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response
(f) any response made in turn by the complainant

On identified dates in September, 2014, four out of sixteen residents and families had concerns that personal items and/or laundry had gone missing over the last year. Interview with the Director of Support Operations indicated that staff, residents, and families report concerns of missing items both verbally and in writing, and that each concern reported is addressed with the appropriate departments; however, a formalized record was not kept. Interview with the Administrator confirmed that concerns related to missing laundry/items were not included on the home's "Resolving Issues Log". [s. 101. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On an identified date in September, 2014 during the medication pass, the registered staff was observed administering medications to residents in the dining room, leaving the medication cart unlocked and unattended while the medication cart was out of their view. This inspector was able to open and close the drawers of the medication cart without the registered staff being aware. The registered staff confirmed that the cart should have been locked. On an identified date in September, 2014 the DOC confirmed the medication cart should always be locked when unattended or out of view of the nurse. [s. 130. 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that, (a) when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the clinical record for resident #400 indicated the resident was administered a medication prior to their bath to aid in responsive behaviours. In September 2014, on three of the eight days that the medication was provided, there was no monitoring of the effectiveness of the drug in the resident's clinical record. Interview with the DOC confirmed the home did not ensure there was monitoring and documentation of the resident's response and the effectiveness of the drug on these dates. [s. 134. (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

The following were observed:
i. On an identified date in September, 2014 two unlabelled used combs and a hairbrush with hair in them on a shelf in the common spa room on the Birch home area.
ii. On an identified date in September, 2014 the spa room on Cedar home area had an unlabelled and used chap stick on the counter. (506)
iii. On an identified date in September, 2014 an unlabelled hair brush with hair in it on a shelf in the common spa room on the Elm home area.
The DOC confirmed that all personal items are to be labelled. (586) [s. 229. (4)]

2. The licensee did not ensure that all staff participated in home`s infection prevention and control program related to hand hygiene.

During the meal observation on an identified date inn September, 2014 in the dining room, a staff member was observed touching several residents and clearing dirty dishes without washing their hands on two occasions. The same staff member then proceeded to assist residents with eating their meals which required them to touch the resident's food with their bare hands. [s. 229. (4)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2013_215123_0020	506
O.Reg 79/10 s. 24. (7)	CO #001	2013_105130_0016	586
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_215123_0020	528
O.Reg 79/10 s. 48. (1)	CO #002	2013_105130_0016	506

Issued on this 7th day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), CYNTHIA DITOMASSO (528), JESSICA PALADINO (586), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_240506_0022
Log No. / Registre no:	H-001250-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, 2014
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_205129_0014, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to resident #007 and resident #104 as specified in their plan.

Grounds / Motifs :

1. Previously issued: WN August 2011; VPC May 2012 and June 2013; and CO August 2014.

The licensee did not ensure that care set out in the plan of care was provided as specified in the plan.

A) Resident #007's plan of care directed staff to have the resident's specified intervention applied during the day to decrease the chance of injury in case of a fall. On an identified date in January, 2014, the health record indicated that the resident did not have their specific intervention applied because one was soiled and sent down to laundry and the other was lost. The resident fell the same day without the specific intervention in place. No injury was detected at that time or in the post fall assessments; however, a possible injury was diagnosed by x-ray on an identified date in January, 2014 and a confirmed injury by a CT scan on an identified date in February, 2014. This information was confirmed by the health record and the DOC. (506)

B) The plan of care for resident #104 identified that they were high risk for falls, and outlined a variety of fall prevention interventions. Review of the resident's fall incident notes included a fall in March 2014, and one in August 2014, where the resident was not wearing their specific intervention at the time of each fall. Interview with registered staff confirmed that the staff did not ensure the resident was wearing hip protectors at the time of their falls in March and August 2014, as specified in the plan of care. (528) (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 08, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

Service Area Office /
Bureau régional de services : Hamilton Service Area Office