Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2021	2021_848748_0004	023727-20, 023728-20, 023729-20, 000126-21, 002411-21, 002412-21, 003220-21, 003371-21	Critical Incident System

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue 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

EMMY HARTMANN (748), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 17, 18, 22, and 23 (as on-site inspection); April 19, 20, and 26, 2021 (as off-site inspection).

The following intakes were completed during this inspection:

Related to abuse and neglect:

Log #003220-21, CIS #2927-000004-21.
Log #003371-21, CIS #2927-000005-21.
Log #000126-21, CIS #2927-000001-21.

Related to follow-up inspections to compliance orders (CO):

Log #002412-21, CO #001 from inspection #2020_866585_0002 regarding s. 6. (7), with a compliance due date (CDD) of March 15, 2021.
Log #002411-21, CO #002 from inspection #2020_866585_0002 regarding s. 23. (1), with a CDD of February 15, 2021.
Log #023729-20, CO #001 from inspection #2020_848748_0002 regarding s. 6. (1), with a CDD February 18, 2021.
Log #023728-20, CO #002 from inspection #2020_848748_0002 regarding s. 24. (1), with a CDD February 18, 2021.
Log #023727-20, CO #003 from inspection #2020_848748_0002 regarding s. 19. (1), with a CDD February 18, 2021.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the acting Director of Care, the acting Assistant Director of Care, Housekeepers, Screeners, registered nurses (RN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

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. 23. (1)	CO #002	2020_866585_0002	632
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2020_848748_0002	748
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2020_848748_0002	748
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_866585_0002	632

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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents were protected from abuse by anyone.

Physical abuse is defined under Ontario Regulation 79/10 as “the use of physical force by a resident that caused physical injury to another resident”.

A review of progress notes identified that there was an altercation between resident #002 and resident #003 on a specified date.

The Skin and Wound Assessment of resident #002 indicated they sustained injuries as a result of the incident, and the RN who conducted the assessment confirmed that the resident sustained injuries as a result of the incident.

A review of resident #003's written care plan identified that the resident exhibited symptoms, and the frequency of an intervention for the symptoms was decreased, 19 days before the altercation. The frequency of the intervention was increased after the altercation took place on a specified date.

Th acting ADOC indicated that based on the progress notes, the day prior to the incident, resident #003 exhibited symptoms.

Sources: resident #002 and resident #003's progress notes, resident #002’s Skin and Wound Assessment, resident #003’s care plan; interview with the acting ADOC, RNs’ #105 and #106 and RPN #110.

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 :

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

In accordance with the LTCHA 2007 section 8. (1) a., every licensee of a long-term care home was to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents and in accordance with O. Reg. 79/10, s. 30 (1) 1., the licensee was to ensure that there were written policies for the organized program of nursing services.

Specifically, staff did not comply with the licensee's Oxygen Policy which indicated that a care plan was to be developed for all oxygen use (as needed & routine) and was to be updated with any changes.

A resident was noted to have low oxygen saturation on a specified date in 2021, and was started on oxygen as a nursing measure. The doctor was made aware of the resident's condition on the same day, and the nurse practitioner saw the resident the following day. An order for oxygen was then obtained two days after, however, there was no care plan focus developed for the oxygen use on point click care (PCC).

The acting DOC verified that oxygen use was not in the care plan on PCC.

Although there was a written plan of care for registered staff related to the use of oxygen, there was a risk that directions related to oxygen therapy would not be relayed to PSWs.

Sources: resident progress notes, physician's orders, Oxygen- Low Flow Policy, last revised October 16, 2020, interview with acting DOC.

Issued on this 3rd day of May, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	EMMY HARTMANN (748), YULIYA FEDOTOVA (632)
Inspection No. / No de l’inspection :	2021_848748_0004
Log No. / No de registre :	023727-20, 023728-20, 023729-20, 000126-21, 002411-21, 002412-21, 003220-21, 003371-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 29, 2021
Licensee / Titulaire de permis :	St. Peter's Care Centres 125 Redfern Avenue, 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 :	Jennifer Banks

To St. Peter's Care Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_848748_0002, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with Long Term Care Homes Act, 2007, s. 19. (1).

Specifically, the licensee shall ensure that:
1. Resident #002 and any other resident in the home are protected from physical abuse by resident #003.
2. Resident #003 is monitored every shift when there is a change in intervention related to their symptoms. A monitoring tool is to be completed and existing and new symptoms are to be documented. The interdisciplinary team is to evaluate the effect of the change in interventions and put in place interventions that are needed to mitigate any risk to the residents.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

Physical abuse is defined under Ontario Regulation 79/10 as "the use of physical force by a resident that caused physical injury to another resident".

A review of progress notes identified that there was an altercation between resident #002 and resident #003 on a specified date.

The Skin and Wound Assessment of resident #002 indicated they sustained injuries as a result of the incident, and the RN who conducted the assessment confirmed that the resident sustained injuries as a result of the incident.

A review of resident #003's written care plan identified that the resident exhibited symptoms, and the frequency of an intervention for the symptoms was decreased, 19 days before the altercation. The frequency of the intervention was increased after the altercation took place on a specified date.

Th acting ADOC indicated that based on the progress notes, the day prior to the incident, resident #003 exhibited symptoms.

Sources: resident #002 and resident #003's progress notes, resident #002's Skin and Wound Assessment, resident #003's care plan; interview with the acting ADOC, RNs' #105 and #106 and RPN #110.

An order was made by taking the following factors into account:

Severity: There was minimal harm to resident #002 as they sustained injuries as a result of the incident.

Scope: The scope of this non-compliance was isolated, because one out of three residents reviewed were physically abused in the home.

Compliance History: A CO is being re-issued for the licensee failing to comply with s. 19. (1) of the LTCHA, 2007. This section was issued as a CO on November 18, 2020, during inspection #2020_848748_0002. In the past 36 months, one Written Notice (WN) and one other CO to this section of the legislation was issued, which had been complied. (632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 10, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Emmy Hartmann

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