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**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 17, 2021 | 2021_877632_0012 | 008093-21 | 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

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): May 25, 26, 27 and 28, 2021.**

**The following Critical Incident System (CIS) intake was completed:**
**log #008093-21 - related to Prevention of Abuse and Neglect and Responsive Behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Supervisor, Behavioral Support Ontario (BSO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Housekeeping.**

**During the course of the inspection, the inspectors toured the home and completed Infection Prevention and Control (IPAC) checklist, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A CIS report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date in May 2021.

Resident #003's written care plan review indicated specified responsive behaviours.

Resident #002's written care plan directed staff to utilize a specified device to alert staff when help was needed for specified actions.

During the inspection, it was observed that the specified device installed at the identified location of resident #002's room did not function as it was expected.

Two additional specified devices in other identified rooms were checked by the Inspector and they did not function as well.

Specified Installation and Use Instructions indicated testing of the specified devices before each use.

The Administrator and the DOC indicated that the specified devices were to be checked by staff before they use them and there were no sign off sheets for the specified devices in the home.

Resident #002 had a potential risk of specified responsive behavior as a result of specified devices not being used in accordance with manufacturers' instructions.

Sources: a CIS Report, residents #002' and #003' written care plans, the Specified Installation and Use Instructions; observations; interview with the Administrator and the DOC.

***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 and ensuring that the staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors, were developed to meet the needs of residents with responsive behaviours.

A CIS Report was submitted to the MLTC on an identified date in May 2021, related to resident to resident abuse.

Resident #002's written care plan indicated that the resident exhibited specified responsive behavior.

During the inspection, resident #003 was observed performing specified activities in the home area. A PSW indicated that resident #003 exhibited specified responsive behaviors.

Resident #003's current written care plan did not identify interventions to manage the resident's specified behaviour, which was acknowledged by the Administrator and the DOC.

Resident #003 was at potential risk of harm posed by other residents as no written strategies, including techniques and interventions, to prevent, minimize or respond to their specified behaviours, were developed to meet the needs of the resident.

Sources: A CIS Report, residents #002' and #003' written care plans; observations; interviews with PSW #111, the Administrator and the DOC.

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**Issued on this 21st day of June, 2021**

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

**Original report signed by the inspector.**