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

Hamilton District
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date: February 2, 2023	
Inspection Number: 2023-1411-0002	
Inspection Type: Critical Incident System	
Licensee: St. Peter's Care Centres	
Long Term Care Home and City: St. Peter's Residence at Chedoke, Hamilton	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature** Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.02.03 12:36:43 -05'00'
Additional Inspector(s) Dusty Stevenson (740739)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 24-27, 2023, January 30, 2023

The following intake(s) were inspected:

- Intake: #00003475- for a Critical Incident related to falls
- Intake: #00004666- for a Critical Incident related to falls

Inspector Farah Khan (695) was present during the inspection.

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, s. 6(10)(b)

The licensee failed to ensure that a resident was re-assessed and the plan of care reviewed and revised in relation to falls, when the resident's care needs changed.

Rationale and Summary

A resident had a fall and the plan of care noted that a specific intervention was initiated after the resident's fall.

Staff stated that the resident did not have the specific intervention in place. A registered staff stated the specific intervention was no longer necessary and should not have been in the care plan.

During the course of inspection, a registered staff revised the resident’s falls plan of care indicating the intervention was no longer needed.

Sources: Resident progress notes, care plan, post fall assessment, and interviews with staff.

Date Remedy Implemented: January 27, 2023 [740765]

WRITTEN NOTIFICATION: Infection Prevention & Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure that they hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

ABHR with expiry dates of January, April, November, and December 2022 were observed inside resident rooms in wall mounted ABHR dispensers on two home areas. At the time of observation, four residents required additional precautions for care and these rooms had expired ABHR.

The Director of Care (DOC) confirmed that expired ABHR should not be used as it does not meet the efficacy of the required 70-90% alcohol content required for healthcare.

Using expired ABHR may have increased the risk of transmission of infections.

Sources: Observation of expired ABHR, interview with DOC, Section H of Infection Prevention & Control (IPAC) Policies & Procedures - Subject Hand Hygiene Program 1.6, and resident care plans.

[740739]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to complete a post-fall assessment for a resident following a fall.

Rationale and Summary

A staff member witnessed a resident falling and intervened to lower them to the ground. A post-fall assessment was not completed at the time because the resident was lowered to the ground.

According to the homes Falls Policy, a fall is defined as an event that results in a person coming to rest inadvertently on the ground, floor or other lower level, and includes when a resident has lost balance and would have fallen if staff did not intervene.

A registered staff confirmed that a post-fall assessment should have been completed for the resident.

By not completing a post fall assessment, circumstances surrounding the fall would not be captured and new interventions implemented.

Sources: Falls Prevention and Post Fall Management Program, interview with staff, resident progress notes and assessments.

[740739]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the strategy to monitor a resident after their fall.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, provides for strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with the home's Head Injury Routine (HIR) policy which was captured in the home's falls prevention and management program.

Rationale and Summary

A resident had an unwitnessed fall and an HIR was started but not completed.

According to the home's policy, every resident who is suspected of having a head injury will receive HIR monitoring for 30 hours following the incident, unless otherwise indicated by the Physician.

The DOC indicated that the home's expectation was that head injury routine be completed in full for unwitnessed falls.

There was potential risk that if the resident had sustained a head injury, it would not have been identified and treated when a complete head injury routine was not conducted.

Sources: Resident 's physical chart, Head Injury Routine Policy, and interview with DOC.

[740739]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident received a clinically appropriate skin assessment when they acquired a new skin alteration.

Rationale and Summary

A resident had sustained a skin alteration and there was no skin assessment completed.

A registered staff stated that new altered skin integrity should have an initial skin assessment completed but one had not been done for the resident's skin alteration.

The resident was at risk for potential worsening skin conditions with no skin assessment completed.

Sources: Resident's progress notes, post fall documentation, care plan, treatment administration records (TAR), Skin and Wound Management Policy, and interviews with staff.

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