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
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 11, 2023	
Inspection Number: 2023-1411-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: St. Peter's Care Centres	
Long Term Care Home and City: St. Peter's Residence at Chedoke, Hamilton	
Lead Inspector Dusty Stevenson (740739)	**Inspector Digital Signature** Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2023.05.17 12:16:17 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 13-14, 17-20, 25-28 and May 1, 2023

The following intake(s) were inspected:

- Intake: #00001137 for a Critical Incident related to alleged improper care/neglect of resident
- Intake: #00019927 Complaint with concerns regarding neglect, continence care and bowel management, plan of care, and pain management
- Intake: #00020634 Complaint with concerns regarding plan of care

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Reporting and Complaints

Pain Management

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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that interventions specific for falls prevention and management were reassessed and plan of care reviewed when a resident's care set out in the plan was no longer necessary.

A resident's plan of care indicated that they required a set of interventions for falls prevention and management.

The inspector observed the resident's room, and the specific interventions were not in place.

A staff member indicated that the resident's care needs had changed and they no longer required the specific falls prevention interventions. The staff member updated the resident's plan of care to reflect their current care needs.

Sources: Resident #001's clinical records, observation resident #001's room, interview with staff #114

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Date Remedy Implemented: May 1, 2023

WRITTEN NOTIFICATION: Licensee to forward complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 22 (1)

The licensee failed to forward a complaint related to the care of a resident to the Director immediately when it was received.

Rationale and Summary
The home received a complaint related to the care of a resident. At the time, the complainant was asked by a staff member if they would like the matter reported to the Ministry and the complainant declined. Nearly two months later the complainant then requested to have the complaint reported to the Ministry. The complaint was then reported to the Ministry two days later.

Two staff members both indicated that the complaint should have been forwarded immediately to the Director as it was concerning the care of a resident.

Sources: CI 2927-000005-22, interview with staff #101 and #100

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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (i)

The licensee failed to provide a skin and wound assessment using a clinically appropriate assessment instrument for a resident upon discovery of skin breakdown.

Rationale and Summary
Staff #106 reported to staff #109 the possible skin breakdown to an identified area of the body of a resident. Staff #109 left a note for the physician to assess. The following day the nurse practitioner prescribed an antibiotic for the skin condition.

A review of the resident's records did not show that a skin assessment was completed for resident’s skin breakdown.

Staff #100 indicated it was the expectation that an initial skin assessment should have been completed for the resident before referring to the physician.

As a result, the skin breakdown was not appropriately captured and documented when it was first reported and the appropriate assessment of the resident’s skin may not have occurred.

Sources: Resident #002's clinical records, interview with staff #109 and staff #100.

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WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 52 (1) 1.

The licensee failed to ensure the home's pain management program provided communication and assessment methods for a resident who could not communicate their pain due to cognitive impairment.

Rationale and Summary
A review of the resident's clinical records indicated that the resident was cognitively impaired and staff # 108 indicated that the resident was unable to communicate their pain due to this.

The resident's electronic medication administration record (eMAR) for November 2021 indicated that the resident's pain level was assessed (on a scale of 0-10) during medication administration of as needed pain medication.

Records for a period in November indicated that pain was recorded as being between 0-1. During this period, pain was also not assessed or not recorded for the resident. According to a letter from the family included in the Critical Incident Report, the family observed the resident in pain during this period.

A staff indicated that the numerical scale that was used to assess pain for the resident was not an appropriate pain assessment method for them as they could not communicate their pain and the family observed the resident in pain during this time.

As a result, the resident may have experienced pain during end-of-life care as the method used to assess their pain level did not appropriately assess their needs.

Sources: CI 2927-000005-22, resident #002 clinical records, interview with staff #108 and #100

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WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The licensee failed to ensure that pain medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A review of a resident's progress notes indicated that an order was written by the Nurse Practitioner and Physician on a day in November 2021 to discontinue the resident's oral pain medication and start subcutaneous pain medication.

The electronic medication administration record (eMAR) indicated that the order was started the following day and was to be provided two times daily. Later that day the pain medication was not administered to the resident and the medication was coded as "drug not available" in the eMAR by a staff member.

In an interview with the staff member they indicated that the drug was not available at the time of administration however the home did have a supply of the pain medication in their narcotic box that should have been provided to the resident.

In the Critical Incident report submitted by the home, it was indicated by the resident's family that the resident was in pain as a result of not receiving their pain medication as ordered.

Sources: Resident #002 clinical records, interview with staff #108, CI 2927-000005-22

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1)

The licensee failed to report an outbreak of public health significance to the Director.

Rationale and Summary
A staff member indicated the home was in outbreak for 11 days in March 2023. The home's outbreak report indicated that a respiratory outbreak that impacted four areas of the home and eleven residents.

A review of the Ministry of Long-Term Care, Long-Term Care Homes Portal showed no critical incident was submitted related to this outbreak.

A staff member indicated that the expectation was the outbreak should have been reported to the Director.

Sources: LTCH Portal, interview staff #100 and #105, Surge Outbreak Report Quality Management Audit Report - 2023-03-07

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