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
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Original Public Report

Report Issue Date: October 17, 2023	
Inspection Number: 2023-1411-0004	
Inspection Type: Critical Incident	
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: 2023.10.26 08:58:04 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20, 22, 26- 29, 2023, and October 3, 2023

The following intake(s) were inspected:

- Intake: #00004686 - for Critical Incident (CI) related to an unexpected death and falls prevention and management.
- Intake: #00011989 - for CI related to skin and wound care and continence care.
- Intake: #00017639 - for CI related to skin and wound care.
- Intake: #00088436 - for CI related to an unexpected death and falls prevention and management.

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

Skin and Wound Prevention and Management
Continence Care
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters To Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that when a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident resulted in harm or a risk of harm to the resident immediately reported this suspicion to the Director.

Rationale and Summary
On a specified date, an incident of improper or incompetent treatment and care for a resident was brought forward to the home. A Critical Incident (CI) report regarding the incident was submitted two days later. The Director of Care (DOC) acknowledged that the incident was not submitted immediately.

Sources: CI report and interview with the DOC. [740765]

WRITTEN NOTIFICATION: General Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program including responses to interventions were documented.

Rationale and Summary
A resident's Point of Care (POC) records indicated multiple missing documentation for their skin assessments and interventions on different shifts and dates on specified dates. A Resident Care Supervisor (RCS) acknowledged that there were missing POC staff documentation, and that documentation were at times inaccurate and inconsistent capturing care.

Failure to document a resident's responses to skin and wound interventions may have resulted in interventions not being implemented or provided.

Sources: A resident's POC records and interviews with staff. [740765]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

A) The licensee has failed to ensure that a resident's altered skin integrity was re-assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident exhibited altered skin integrity from specified dates. Their records indicated two skin re-assessments on their altered skin completed nine and 13 days apart from specified dates. The DOC acknowledged that skin re-assessments were to be completed weekly, within a seven-day period, per altered skin site or area and to be ongoing until resolved. They stated more than seven days for a re-assessment does not meet the requirements for the home's skin and wound management protocols.

B) The licensee has failed to ensure that a resident's altered skin integrity was re-assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
On a specified date, a resident exhibited altered skin integrity. Their records from specified dates indicated three skin re-assessments on their altered skin completed between nine to 12 days apart. The DOC acknowledged that skin re-assessments were to be completed weekly and more than seven days for a re-assessment does not meet the requirements for the home's skin and wound management protocols.

Failure to re-assess both residents' skin at least weekly posed a potential risk for identifying the worsening of their skin.

Sources: Residents' clinical records, Skin and Wound Management Policy, and interview with DOC and staff. [740765]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee failed to ensure that the Director was immediately informed of an unexpected or sudden death that included a death resulting from an accident.

Rationale and Summary
A CI report was submitted on a specified date about a resident's unexpected death that occurred the previous day. The DOC acknowledged that the incident was not submitted immediately. No after hour phone line submission was completed.

Sources: CI report and interview with the DOC. [740765]