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

Public Report

Report Issue Date: January 20, 2025

Inspection Number: 2025-1411-0001

Inspection Type:
Complaint
Critical Incident

Licensee: St. Peter's Care Centres

Long Term Care Home and City: St. Peter's Residence at Chedoke, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 7-10, 13-17, 20, 2025

The following intakes were inspected:

- Intake: #00125360/CI#2927-000025-24 was related to a missing controlled substance
- Intake: #00128473/CI#2927-000030-24 was related to alleged neglect of a resident
- Intake: #00128615/CI#2927-000031-24 was related to infection prevention and control
- Intake: #00129941/complainant related to medication management and continence care
- Intake: #00130527/CI#2927-000036-24 was related to alleged physical abuse
- Intake: #00134873/CI#2927-000047-24 was related to a fall resulting in injury

The following intakes were completed:

- Intake: #00122812/CI#2927-000020-24, intake: #00123623/CI#2927-000022-24, intake: #00125064/CI#2927-000024-24, and intake:

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#00131015/CI#2927-000037-24 related to falls prevention and management

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

Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and 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)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with

respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 Additional Requirement under the Standard indicated that the licensee should make personal protective equipment (PPE) available and accessible to staff appropriate to their role and level of risk.

The licensee has failed to ensure that the required PPE was accessible at point of care for staff providing care to specified residents on additional precautions.

Later in the inspection, it was noted that the required PPE was accessible at point of care for the specified residents.

Sources: Observations, interviews with staff.

Date Remedy Implemented: January 8, 2025

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was re-assessed and their plan of

care reviewed and revised when the care set out in the plan was not effective related to pain management.

Staff noted a resident's as needed (prn) pain medication was not effective and an urgent referral to the Nurse Practitioner (NP) was initiated for re-assessment of the resident's pain medication. Another referral to the NP was initiated the next day due to increased pain after another fall.

The NP stated if the NP was not available the on-call Physician should have been called when the strategies were ineffective for managing the resident's pain.

Sources: clinical health record of resident, including assessments, referrals, progress notes, eMAR for December 2024 and January 2025; interview with staff and NP.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect a resident from neglect by a personal support worker.

Section 7 of the Ontario Regulation (O. Reg.) 246/22 defined neglect as "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A resident was left unattended for a period of approximately one hour on the toilet, which resulted in an area of skin impairment, pain, discomfort and frustration. At the time of the incident, the resident's washroom call bell was not within reach and they were unable to call for staff assistance.

Sources: Resident's clinical record, long-term care home (LTCH) investigation records, critical incident system (CIS) 2927-000030-24, policy #D5.3 "Safe Client Handling, Lifts and Transfers" (reviewed October 16, 2024), manual #04.KL.00.EN_4 "Instructions for Use Sara Flex" (dated May 2019), interviews with the Director of Care (DOC), resident and PSW.

The licensee has failed to protect a resident from abuse by another resident.

Section 2 (1) (c) of Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On a specified date, a resident kicked another resident. In response to this, the resident kicked the other resident back and as a result they sustained a skin tear.

Sources: Progress notes for both residents, resident's clinical records, interview with staff, CIS 2927-000036-24.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure a resident's plan of care was based on, at a minimum, interdisciplinary assessment their health conditions.

A resident required a specified level of assistance. Due to a special need, the placement of the call bell in their washroom was not accessible to them.

The plan of care did not set out direction for staff related to ensuring call bell access during toileting care, based on the resident's special need.

Sources: Observation of resident's washroom, resident's clinical record, critical incident system (CIS) 2927-000030-24, policy #J1.4 "Call Bell System" (reviewed September 20, 2023), interviews with the Director of Care (DOC), Physiotherapist and resident.

WRITTEN NOTIFICATION: General Requirements - documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under Infection Prevention and Control program, including assessments related to monitoring a resident's infection on two specified night shifts and one afternoon shift, were documented, which was confirmed by the registered nurse (RN).

Sources: Resident's clinical records; interview with staff.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home has failed to ensure the pain management program was followed for a resident.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a pain management program to identify pain in residents and manage pain, and that it was complied with. Specifically, staff did not comply with the "Pain Management" policy, which required staff to complete a pain assessment tool when a resident screened positive for pain.

A resident exhibited pain to a specified area of the body. A pain assessment was not completed using a clinically appropriate tool as prompted by the home's pain management policy.

Sources: Resident's clinical record, policy #J8.0 "Pain Management" (reviewed November 9, 2023), interview with the Director of Care (DOC) and resident.

WRITTEN NOTIFICATION: Pain management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

As needed pain medication was provided to a resident on a specified date. The medication was deemed ineffective and no further narcotic pain medications were provided that day. The resident's pain was not re-assessed until the following day and an urgent referral to the NP was initiated related to the ineffective pain medications.

Sources: Clinical health record for resident, including progress notes, eMAR, pain records under vitals tab, narcotic administration records; interview with staff and DOC; policy "Pain Management Program", revised November 9, 2023.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure the Director was informed of an incident of missing or unaccounted for controlled substances no later than one business day after the occurrence of the incident. A specified quantity of two separate controlled substances were unaccounted for at the time of controlled substance destruction and the Director was not informed until seven days later.

Sources: Critical incident system (CIS) 2927-000025-24, long-term care home (LTCH) investigation records, interviews with the DOC and Clinical Pharmacist Consultant.

WRITTEN NOTIFICATION: Medication Management System

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to implement their drug destruction policy related to removing expired drugs from the active drug supply for a resident when two different medications were administered to a resident eight and nine days following their expiry date.

Sources: Resident's clinical records, policy #9.1 "Drug Destruction: Non-controlled Substance" (revised September 2023) and reference document (Recommended Expiry Dates), interview with staff.

The licensee has failed to implement their drug storage policy related to dating a specified medication after first use with an expiry date. It was identified on a specified date that a medication had been administered to a resident that was not dated with an expiry date and it is not known when it was first opened.

Sources: Resident's clinical records, policy #7.1 "Drug Storage: Non-controlled Substance" (revised September 2023) and reference document (Recommended Expiry Dates), interview with staff.

The licensee has failed to implement their medication administration policy when a resident was provided a medication for administration at the incorrect time.

During the inspection, an inspector observed the Substitute Decision Maker (SDM) for a resident inform a PSW that the resident was provided the incorrect medication for the specified administration time. The PSW informed nurse and the correct medication was provided.

Sources: observation, interview with staff, resident's clinical records, policy# 7.22: "Instillation of Eye Drops and Medications" (revised October 7, 2024).

The licensee failed to implement their controlled substances destruction policy, where the controlled substance pending destruction was to be placed in the designated double-locked area with two registered staff members present. An RPN did not witness the disposal of a specified quantity of controlled substance by their co-RPN, as they had their back turned to their co-RPN and were completing another task.

Sources: Long-term care home (LTCH) investigation records, policy #9.2 "Drug Destruction - Controlled Substances" (revised September 2023), interviews with the DOC and staff.

The licensee failed to implement their controlled substances destruction policy, where the Controlled Substance Administration Record was to be kept in the resident's chart and a photocopy kept by the DOC. Two incidents of missing controlled substances were identified and the administration record for both residents was not demonstrated to the inspector by the conclusion of inspection activities.

Sources: Resident's physical charts, LTCH investigation records, policy #9.2 "Drug Destruction - Controlled Substances" (revised September 2023), interview with the DOC.

WRITTEN NOTIFICATION: Resident records

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and

The licensee has failed to ensure responsive behaviour monitoring records were maintained for a resident.

According to the resident's progress notes, a responsive behaviours monitoring tool was initiated on a specified date for the resident following an altercation with another resident. The monitoring document could not be produced when it was requested from the home.

Sources: Resident's clinical records, interviews with staff.