**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 18, 2013 | 2013_226192_0008 | L-000666-13 | Complaint |

**Licensee/Titulaire de permis**

SAINT LUKE'S PLACE
1624 Franklin Blvd., CAMBRIDGE, ON, N3C-3P4

**Long-Term Care Home/Foyer de soins de longue durée**

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD, CAMBRIDGE, ON, N3C-3P4

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

DEBORA SAVILLE (192)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 11, 12, 2013.**

**Inspector Deirdre Boyle participated in completion of this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Registered Nurses, Registered Practical Nurses, Educator, Personal Support Workers, Wound Care Nurse and family.**

**During the course of the inspection, the inspector(s) reviewed medical records, policies and procedures, schedules and incident reports.**

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

**Medication**

**Personal Support Services**

**Reporting and Complaints**

**Findings of Non-Compliance were found during this inspection.**

| 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 | Legendé<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. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

Dietary Manual Policy Number D1007 Revised August, 2013 states:
"Only residents with orders for supplement will receive therapeutic nutritional supplements," and Nutritional supplements are to be ordered by the Registered Dietitian or Physician.

Progress Notes dated August 2013 indicated Resident #001 refused lunch and received 125 millilitres (ml) of supplement. There is no order for supplement by a Registered Dietitian or a Physician in the medical record. [s. 8. (1)]

2. The Home's policy titled Skin and Wound - Program Assessment and Monitoring policy number N-I-J-27 revised April 2013 indicates that Registered Staff will complete the Braden Scale and physical assessment on admission and readmission.

Resident #003 was admitted in 2013 with an identified open area. No assessment was completed until four days after admission and no interventions were initiated as of the date of this inspection. Staff interview confirms that assessment was not completed until four days after admission and no interventions were provided. [s. 8. (1)]

*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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

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

**s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:**
**7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).**

**s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that the 24 hour admission care plan included at a minimum, the following with respect to Resident #003: Skin condition, including interventions.

Interview with Registered Staff and the progress note for a specified date and time identified that at the time of admission, family advised staff that the Resident had a pressure area.

Interview with Registered Staff and review of the skin and wound assessment and treatment record identify that the open area on Resident #003 was not assessed until four days following admission. Interview also identified interventions required related to the open area; including the application of cream, repositioning and encouraging the Resident to rest on their bed between meals were not included in the 24 hour care plan.

The care plan available to staff providing care for Resident #003 dated June 2013 and September 2013, does not include the presence of an open area or interventions required. [s. 24. (2) 7.]

2. The licensee failed to ensure that the care set out in the care plan is provided to the resident as specified in the plan.

The care plan for Resident #001 indicated that they were to have specified stockings applied daily.

The treatment record indicated Registered Staff were to document the application of the stockings each morning and removal at bedtime.

Interview with the Substitute Decision Maker (SDM) confirmed that on a specified date in 2013 the Resident was observed with no compression stockings, even though they had been provided by the SDM and instruction on application had been provided on admission. [s. 24. (6)]

***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 ensuring that the 24 hour admission care plan includes at a minimum, the following: Skin condition, including interventions, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**s. 101. (3) The licensee shall ensure that,**
**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**
**(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).**
**(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a documented record kept in the home includes every date on which any response was provided to the complainant and a description of the response.

A review of the Complaint Tracking Log related to the August 2013 complaint involving resident #001 does not include the date the complainant was contacted regarding the investigation. The Complaint Tracking Log does not contain information regarding the communication between the Director of Care and the complainant in August 2013.

Interview with the complainant in August 2013 identified that the DOC communicated the current status of the investigation and that the investigation was still in progress. [s. 101. (2)]

2. The licensee failed to ensure that the documented record of complaints is reviewed and analyzed for trends at least quarterly; the results of the review and analysis are taken into account in determining what improvements are required in the home; and that a written record is kept of each review and of the improvements made in response.

The Home was unable to provide documentation related to the analysis of trends and a written record of a review of complaints having been completed.

Interview with the Executive Director confirms that no written documentation of the analysis of trends and the improvements made in response are available in the Home. [s. 101. (3)]

Issued on this 18th day of September, 2013

| Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs |
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