Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 18, 2020	2020_798738_0015	002680-20, 003018-20, 010541-20, 010544-20, 011278-20	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

AMANDA OWEN (738), JANETM EVANS (659)

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): July 22-24, 28-31, and August 4-5, 2020.

The following intakes were completed in this Complaint inspection:
- Log #003018-20/Critical Incident (CI) #C568-000010-20, related to medication administration;
- Log #002680-20/CI #C568-000009-20, related to alleged neglect;
- Log #010544-20/CI #3014-000009-20 and Log #010541-20/CI #3014-000010-20, related to continence care and alleged neglect; and
- Log #011278-20/CI #3014-000012-20, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing and Personal Care (DONPC), Assistant Director of Nursing and Personal Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents. The inspector also toured the home, observed care provision, and reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Records showed that residents #004, #011, and #012 had areas of altered skin integrity on specified dates.

Skin and Wound Weekly Assessments were reviewed and showed the areas of altered skin integrity were not reassessed on multiple dates.

Staff member #116 and Best Practice RPN/Skin and Wound Lead #102 stated areas of altered skin integrity were to be reassessed weekly and documented in Point Click Care under Skin and Wound Weekly Assessments. They confirmed resident #004, #011, and #012's areas of altered skin integrity were not assessed as required.

The licensee failed to ensure that resident #004, #011, and #012's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

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 to ensure residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone occurred that resulted in harm or risk of harm, that they immediately reported the suspicion and the information upon which it was based to the Director.

Staff member #106 stated that on a specified date they received a report that resident #004 displayed a responsive behaviour during the night shift. When they went into the resident's room that morning, they observed areas of altered skin integrity on the resident.

Staff member #109 stated that on a specified date, resident #004 appeared to be afraid of them when they went into their room to provide morning care. They observed areas of altered skin integrity on the resident that were not previously there.

A document titled, Saint Luke's Place - Incident Investigation Report, documented that a staff member reported to the DONPC that some staff were concerned about the areas of altered skin integrity on resident #004. It documented the incident involved suspected physical abuse.

DONPC #101 acknowledged that they were made aware of the incident on a specified date, but the incident was not reported to the Director.

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of resident #004 had occurred that resulted in harm or risk of harm, that they immediately reported the suspicion and the information upon which it was based to the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The following is further evidence to support Compliance Order #001 from inspection #2020_773155_0006 issued on July 3, 2020.

A Critical Incident Report was submitted to the Director on a specified date. It documented that resident #013's medical directive was used to administer them a medication for pain on specified dates. It said the medical directive could only be used for 48 hours. After that, the physician should be notified.

Resident #013's electronic medication administration record was reviewed and showed they received the medication on specified dates. However, according to the progress notes, the physician was not notified until after the medication had been administered on multiple dates.

Staff member #111 confirmed resident #013 had received the medication more than two days in a row before the physician was notified.

The licensee failed to ensure that drugs were administered to resident #013 in accordance with the directions for use specified by the prescriber.

Issued on this 19th day of August, 2020

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

Original report signed by the inspector.