

**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

**Amended Public Copy/Copie modifiée du rapport public**

<b>Report Date(s)/ Date(s) du Rapport</b>	<b>Inspection No/ No de l'inspection</b>	<b>Log #/ No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 18, 2021	2020_800532_0026 (A1)	020644-20, 021080-20, 021125-20	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**

Amended by NUZHAT UDDIN (532) - (A1)

**Amended Inspection Summary/Résumé de l'inspection modifié**

**Extension of CDD is granted in order to have sufficient time for staff education given the impact of recent COVID outbreaks.**

**Issued on this 18th day of January, 2021 (A1)**

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

**Original report signed by the inspector.**

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

Amended by NUZHAT UDDIN (532) - (A1)

**Amended Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): November 16-24, 2020.**

**Log #021125-20, IL-83850-CW related to abuse.**

**Log #021080-20, related to late reporting.**

**Log #020644-20, related to abuse.**

**This Complaint inspection was completed concurrently with a Critical Incident inspection #2020\_738753\_0027.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DONPC), Assistant Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a family member and residents.**

**The inspector also toured resident home areas, observed resident care provision, resident staff interaction, and reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation  
Skin and Wound Care**

During the course of the original inspection, Non-Compliances were issued.

3 WN(s)  
2 VPC(s)  
1 CO(s)  
0 DR(s)  
0 WAO(s)

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.)</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure residents were protected from neglect by the staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.”

A) A resident was neglected when care required for health, safety and well being was not provided for an identified amount of time resulting in a skin concern.

Sources: CIS, RN interview, PSW and the DONPC, investigative notes, resident’s electronic chart including progress notes, and care plan. (753)

B) A complaint was received by the home that a resident did not receive care when they were incontinent, and the toilet seat was also soiled and dirty. The resident was incontinent and was not changed by the staff.

The DONPC completing the investigation was not sure how long the resident was incontinent for and the soiled bathroom was not cleaned as part of the daily routine. The resident not being provided care posed a potential risk to the resident's skin integrity.

Source: Complaint Record and interview with DONPC. [s. 19. (1)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.**

**(A1)**

**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**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 :**

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durée**

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) An alleged incident of abuse was witnessed by a staff member but it was not reported until the next day. There was potential risk of harm to other residents by not reporting the alleged abuse immediately.

Source: CIS, PSW, PSW and the DONPC.

B) A complaint was received about an incident of alleged neglect. The DONPC did not immediately report the allegation of neglect to the Director, resulting in potential risk of harm to the resident.

Source: Complaint Record and interview with the DONPC.

C) An allegation of abuse was reported to the management but the allegation was not reported to the Director immediately.

There was minimal risk of harm as the staff member did work again prior o the incident being reported.

Sources: CIS, interview with RN and the DONPC. (753) [s. 24. (1)]

***Additional Required Actions:***



**Inspection Report under  
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***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 that 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: 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, to be implemented voluntarily.***

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**WN #3: 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 :**

**Inspection Report under  
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1. The licensee has failed to ensure that a resident, who exhibited altered skin integrity, received 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.

An area of skin concern was identified for a resident.

There was no skin assessment completed by the registered nursing staff when the resident exhibited the skin concern. This posed a potential risk of harm as appropriate interventions may not have been put in place to address the skin concern.

Sources: Interviews with RN, resident's electronic record including assessments, progress notes, care plan and risk management, investigative notes. [s. 50. (2) (b) (i)]

***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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.***

**Issued on this 18th day of January, 2021 (A1)**

**Inspection Report under  
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de la Loi de 2007 sur les  
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durée**

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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

**Amended Public Copy/Copie modifiée du rapport public**

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**Name of Inspector (ID #) /  
Nom de l'inspecteur (No) :** Amended by NUZHAT UDDIN (532) - (A1)

**Inspection No. /  
No de l'inspection :** 2020\_800532\_0026 (A1)

**Appeal/Dir# /  
Appel/Dir#:**

**Log No. /  
No de registre :** 020644-20, 021080-20, 021125-20 (A1)

**Type of Inspection /  
Genre d'inspection :** Complaint

**Report Date(s) /  
Date(s) du Rapport :** Jan 18, 2021(A1)

**Licensee /  
Titulaire de permis :** Saint Luke's Place  
1624 Franklin Blvd., Cambridge, ON, N3C-3P4

**LTC Home /  
Foyer de SLD :** Saint Luke's Place  
1624 Franklin Boulevard, Cambridge, ON, N3C-3P4

**Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur :** Maureen Toth

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To Saint Luke's Place, you are hereby required to comply with the following order(s)  
by the date(s) set out below:

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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**Order # /****No d'ordre:** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

- 1) Retrain agency PSW's and all staff assigned to provide one to one care for a resident on the resident's plan of care related to continence. Retrain all direct care staff on prevention of abuse and neglect policy.
- 2) Document the education that is provided to all direct care staff and include the date, the content of the education and the staff member who provided the education.

**Grounds / Motifs :**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that a resident was free from neglect by the staff in the home.

For the purpose of the Act and this Regulation, "neglect" means the 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. O. Reg. 79/10, s.5.

A complaint was received by the home that a resident did not receive care when they were incontinent, and the toilet seat was also soiled and dirty. The resident was incontinent and was not changed by the staff.

The DONPC completing the investigation was not sure how long the resident was incontinent for and the soiled bathroom was not cleaned as part of the daily routine. The resident not being provided care posed a potential risk to the resident's skin integrity.

Source: Complaint Record and interview with DONPC [s. 19. (1)] (532)

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

2. The licensee has failed to ensure a resident was protected from neglect by the staff in the home.

A resident was neglected when care required for health, safety and well being was not provided for an identified amount of time resulting in a skin concern.

Sources: CIS, RN interview, PSW and the DONPC, investigative notes, resident's electronic chart including progress notes, and care plan. (753)

An order was made by taking the following factors into account:

Severity: The two residents were neglected when care required for health, safety and well being was not provided to the residents which posed a potential risk to their skin integrity.

Scope: This was a pattern as two out of three residents were neglected resulted in potential harm to residents.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with LTCHA s. 19 (1) and one Compliance Orders (CO), one VPC and a WN was issued to the home. Three other COs were issued to different sections of the legislation, all of which have been complied. (753)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :**

Feb 19, 2021(A1)

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION****TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:



**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 18th day of January, 2021 (A1)**

**Signature of Inspector /  
Signature de l'inspecteur :**

**Name of Inspector /  
Nom de l'inspecteur :**

Amended by NUZHAT UDDIN (532) - (A1)

**Order(s) of the Inspector**

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foyers de soins de longue durée*, L.O.  
2007, chap. 8

**Service Area Office /  
Bureau régional de services :**

Central West Service Area Office