

**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) 885-2015Bureau 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**

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 13, 2021	2021_739694_0014 (A1)	025487-20	Follow up

Licensee/Titulaire de permisSaint 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 AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension of compliance due date from April 23, to April 30, 2021, as requested by the home's administrator.

Issued on this 13th day of April, 2021 (A1)

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

Original report signed by the inspector.

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

Rapport d'inspection en vertu
de la Loi de 2007 sur les
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Long-Term Care Operations Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 13, 2021	2021_739694_0014 (A1)	025487-20	Follow up

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 AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 10, 11, and 12, 2021.

This inspection was conducted concurrently with Critical Incident System (CIS)

**Inspection Report under
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durée**

Inspection #2021_739694_0015.

The following intakes were inspected during this follow up inspection:

**Log #025487-20, related to a follow up of CO #001 from inspection
#2020_800532_0026, related to duty to protect.**

**NOTE: A Written Notification related to Long-Term Care Homes Act (LTCHA), 24
(1), and a Compliance Order was re-issued related to LTCHA, s. 19 (1), that was
identified in a concurrent inspection #2021_739694_0015, Log #003425-21,
related to alleged abuse was issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the
Administrator, Director of Nursing and Personal Care (DONPC), Registered
Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers
(PSW), activation staff, and residents.**

**The inspector also toured the home, observed the provision of care and
services, reviewed relevant documents, including but not limited to clinical
records, policies and procedures, internal investigation and training records.**

The following Inspection Protocols were used during this inspection:

**Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation**

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

**2 WN(s)
0 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 :

**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**

1. The licensee has failed to ensure a resident was protected from abuse by a staff member in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”.

Multiple staff heard a staff member raise their voice and argue with a resident.

The resident cried after the incident and stated they hated being treated like a child.

Failing to ensure the resident was protected from verbal abuse by a staff member belittled and upset the resident.

Sources: DONPC interview, investigative notes, resident’s electronic chart including progress notes, and care plan. [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**

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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of residents reported 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).

The following is further evidence to support the order issued on March 3, 2021, during inspection 2021_792659_0003 to be complied by April 5, 2021.

Staff witnessed a staff member exhibit verbally abusive behaviour towards residents. The incidents were not reported until three days later, when a critical incident report was submitted to the Director.

Staff not reporting the suspected verbal abuse immediately, put residents at further risk of harm by the staff member.

Sources: Interviews with DOC, review of the resident's clinical record, and the home's policy "Prevention, Reporting and Elimination of Resident Abuse". [s. 24. (1)]

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durée**

Issued on this 13th day of April, 2021 (A1)

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

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**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** Amended by AMANDA COULTER (694) - (A1)

**Inspection No. /
No de l'inspection :** 2021_739694_0014 (A1)

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

**Log No. /
No de registre :** 025487-20 (A1)

**Type of Inspection /
Genre d'inspection :** Follow up

**Report Date(s) /
Date(s) du Rapport :** Apr 13, 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

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

Order # / No d'ordre: 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
Linked to Existing Order / Lien vers ordre existant:	2020_800532_0026, CO #001;

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) Ensure the identified resident is not verbally abused by staff.
- 2) Ensure the three identified staff members receive re-education on the prevention of abuse and neglect policy, including identifying and reporting all types of abuse.
- 3) A written record of the education that is provided to the three staff members is kept and includes 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 a resident was protected from abuse by a staff member in the home.

The licensee has failed to comply with compliance order #001 from inspection number 2020_800532_0026, issued January 18, 2021, with a compliance due date of February 19, 2021.

Section 2 (1) of the Ontario Regulation 79/10 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”.

Multiple staff heard a staff member raise their voice and argue with a resident.

The resident cried after the incident and stated they hated being treated like a child.

Failing to ensure the resident was protected from verbal abuse by a staff member belittled and upset the resident.

Sources: DONPC interview, investigative notes, resident’s electronic chart including progress notes, and care plan. [s. 19. (1)]

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

Severity: A resident was caused actual harm after they felt belittled by a staff member.

Scope: One out of two residents were affected.

Compliance history: In the last 36 months the home had previous non-compliance to the same subsection that included compliance order #001 from inspection 2020_800532_0026 issued January 18, 2021, with a compliance due date of February 19, 2021. Six other compliance orders, seventeen voluntary plan of corrective action (VPC) and twenty-nine written notifications (WN) have been issued. (694)

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

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Apr 30, 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.

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

**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^e 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

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

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.

Issued on this 13th day of April, 2021 (A1)

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

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

Amended by AMANDA COULTER (694) - (A1)

Order(s) of the Inspector

Pursuant to section 153 and/or
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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

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

Central West Service Area Office