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

Original Public Report

Report Issue Date: August 15, 2024
Inspection Number: 2024-1411-0003
Inspection Type: Critical Incident
Licensee: St. Peter's Care Centres
Long Term Care Home and City: St. Peter's Residence at Chedoke, Hamilton

Lead Inspector	**Inspector Digital Signature**
Indiana Dixon (000767)	Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2024.08.16 08:03:35 -04'00'

Additional Inspector(s) Dusty Stevenson (740739)

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): August 6, 7, 8, 9, 12, 13, 2024

The following intake (s) were inspected:

- Intake: #00113845 – [Critical Incident (CI): 2927-000009-24] related to Prevention of Abuse and Neglect.
- Intake: #00114932 – [CI: 2927-000013-24] – related to Skin and Wound Prevention and Management.
- Intake: #00117989 – [CI: 2927-000015-24] related to Falls Prevention and Management.
- Intake: #00120318 – [CI: 2927-000018-24] related to Prevention of Abuse and Neglect/Responsive Behaviours.

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The following intake was completed in this inspection:

- Intake: #00109536 – [CI: 2927-000002-24] related to Falls Prevention and Management.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the care set out in a resident's plan of care provide clear direction to staff and others who provide direct care to the resident.

Rationale and Summary
A resident's written plan of care did not convey the same information as a handwritten signage above their bed regarding a specific intervention. This was acknowledged by staff.

Sources: A resident's care plan, observation, and interviews with staff.

Date Remedy Implemented: August 9, 2024

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure a resident's right to freedom from abuse.

Rationale and Summary
The Director received a report from the home, indicating that a resident was observed touching another resident inappropriately. Staff stated that the behaviour went against a resident's rights to freedom from abuse and neglect.

Sources: Residents' progress notes, and interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident received a specific intervention as indicated in their plan of care.

Rationale and Summary
On a specified date, a resident did not receive a specific intervention to help stabilize their health condition.

Sources: A resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #004 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 abuse.

Rationale and Summary
On a specified date, a resident entered another resident's room and forcibly removed them from their room.

Failing to address a resident's behavioural trigger and putting interventions in place put another resident at risk and resulted in a physical altercation between the residents.

Sources: Interviews with staff, residents' clinical records, video footage of incident.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to complete a weekly skin assessment for a resident on two occasions.

Rationale and Summary
Review of a resident's clinical records indicated that a weekly skin assessment was not completed for a specific period.

Failing to assess a resident's wound weekly may have delayed interventions that could have promoted healing.

Sources: A resident's clinical records, interview with staff, policy: Skin and Wound Care.

WRITTEN NOTIFICATION: Pain management

NC #006 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 assess a resident for pain when an initial intervention for pain was found to be ineffective.

Rationale and Summary

A resident was provided a pain medication to help stabilize their pain. The resident's clinical records indicated that the pain intervention was not effective.

A pain assessment was not completed when the interventions were ineffective.

Sources: A resident's clinical records, interview with the staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to document a resident's response to interventions related to their responsive behaviours.

Rationale and Summary
A resident's clinical records did not include documentation to support that the interventions were trialed nor of the resident's response to the interventions.

Failing to document the ineffectiveness of responsive behaviour interventions for a resident may have delayed the implementation of new interventions.

Sources: A resident's clinical records, interview with staff, and observations.

WRITTEN NOTIFICATION: Notification re incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident and their Substitute Decision Maker (SDM) were immediately notified of the outcome of an investigation.

Rationale and Summary
The home submitted a Critical Incident Report (CIR) regarding an allegation. When the home completed their internal investigation, they did not inform the resident nor their SDM of the results.

Sources: Investigation notes, a resident's progress notes and interviews with staff.