Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_276537_0040	010846-15	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - MARIAN VILLA
200 COLLEGE AVENUE P.O. BOX 5777 LONDON ON N6A 1Y1

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

NANCY SINCLAIR (537)

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 29, 2015

This Complaint Inspection is related to allegations of abuse to a resident and a critical incident the home submitted as a result.

Amie Gibbs-Ward(630) was also at this inspection.

During the course of the inspection, the inspector(s) spoke with a Family member, the Administrator, Director of Care, and the Assistant Director of Care.

The inspector(s) also reviewed a clinical record and plan of care for an identified resident, and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	Legendé 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. 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system, instituted or otherwise put in place:
b) was complied with.

1)A family member of an identified resident noted an area of altered skin integrity while visiting. On consultation with the Administrator, the family requested that this be investigated and the reason for the alteration in the skin integrity to be determined. As a result, the home initiated an internal investigation which revealed that this area had been previously reported to Registered staff on two occasions and had not been documented in Point Click Care (PCC) documentation. As a result of the investigation, the staff members completed late entry documentation into PCC.

The home's policy – Skin Care and Assessment, and Wound Management, revised July 2014, indicated the following:
If any interdisciplinary health care team member observes or identifies any skin care issues or wounds in the course of providing care to the resident, that member must report their observations to the unit nurse.
Any skin issues, wound, rashes, etc. that are identified on the head-to-toe assessment are documented in the Progress Notes of the resident's chart in the electronic documentation system or using the "Wound/Skin Assessment" in the electronic documentation system. This is done by the nurse who performed the assessment. This documentation includes the staging of any identified wounds.

The Administrator and the Director of Care verified that the documentation was not completed at the time the skin care issues were identified and Wound/Skin Assessments had not been completed.

The Administrator and the Director of Care confirmed the home's expectation was that the documentation and assessment were completed as per the home's Skin Care and Assessment, and Wound Management policy.

2)Interview with the family of an identified resident indicated the family member received a phone call from the home that indicated the resident had deceased and that the home was requesting funeral home information to release the body. The complainant was not provided with any specific details or information regarding the death of the resident.

The home's policy, Death of a Resident, revised April 2014, indicated the following: The RN or RPN documents in the Progress Notes a clear, concise account of the death, the time that the next-of-kin and funeral home were notified, and other pertinent date, e.g. autopsy.

The Administrator and the Director of Care confirmed there were omissions in the documentation in the progress notes and it was the home's expectation that specific details related to the death would be documented in the progress notes, as per the home's Death of a Resident policy. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system, instituted or otherwise put in place:
b) is complied with, to be implemented voluntarily.

Issued on this 19th day of October, 2015

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

Original report signed by the inspector.