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
Dec 23, 2015	2015_260521_0057	014914-15, 023884-15, 023124-15, 022173-15	Critical Incident System

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

REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 7, 8, 9, 2015.

This inspection was completed concurrently with Critical Incident Logs #023124-15/CI C537-000018-15 relating to unlawful conduct; #022173-15/CI C537-000019-15 relating to abuse; #023884-15/CI C537-000020-15; relating to abuse and #014914-15/CI C537-000012-15 relating to abuse.

During the course of the inspection, the inspector(s) spoke with The Administrator, both Directors of Care, a Registered Nurse, a Registered Practical Nurse, a Personal Support Worker and a resident.
During the course of the inspection, the inspector(s) also reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Observations of the Tub room Y519 revealed the door to the tub room was held open by a pink tied plastic bag leashed around the door handle and attached to the wall.

Inside the tub room were stored containers of disinfectant, mouthwash and razors. The floor surface area was covered in water approximately one metre by one metre. The radio was playing louder than talking level.

The open door, unlocked hazards and wet floor were confirmed by the Registered Practical Nurse (RPN).

The Director of Care confirmed it was the home's expectation that the tub room doors should be locked when not in use and the home was a safe and secure environment for its residents. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 was complied with.

A review of a Critical Incident Report submitted to the Ministry Of Health revealed a companion for a Resident had reported observations of skin changes to the Registered Practical Nurse.

A record review revealed the Registered Practical Nurse (RPN) had not documented the observations reported or an assessment in the resident chart and had not notified the resident's Substitute Decision Maker (SDM) of the observed skin changes.

A review of the Policy - Skin Care and Assessment, revised July 2014, revealed, "any skin issues are documented in the progress notes of the resident chart in the electronic documentation or using the "Wound/skin Assessment". The unit nurse informs the Substitute Decision Maker of all wound care treatment measures and for residents receiving daily hands on care from staff the staff observes the resident's skin daily for reddened areas, actual or potential skin breakdown, rashes, open areas, blisters, skin tears, etc. The staff would notify the registered staff of any unusual findings."

An interview with the Director of Care confirmed the Resident required daily care and it was the home's expectation that the Registered Practical Nurse should have documented the observations and assessment of skin changes of the resident in the resident record and informed the SDM of the ongoing monitoring.

The licensee failed to ensure that the homes's Policy – Skin Care and Assessment was complied with. [s. 8. (1) (a),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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

Observations revealed during an interview with a resident it was determined the resident required assistance. The resident to staff communication and response system was not able to be activated by Inspector or the Resident.
The Personal Support Worker verified the communication and response system was not functioning.

An interview with the Resident revealed the communication and response system had not been functioning for the last 24 hours and it had been reported to the staff on duty 24 hours prior.

An interview with the Registered Nurse confirmed it was the home's expectation that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

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 the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

A record review of a Critical Incident Report reported to the Ministry of Health and Long Term Care and progress notes revealed an incident of alleged abuse between two residents was observed by staff in the summer of 2015. The incident was not reported until two days later to the Ministry of Health.

A Registered Nurse on duty received a call from a Substitute Decision Maker concerned that a resident had been injured.
The Critical Incident Report revealed the incident regarding the Resident was not reported to the Ministry of Health and Long Term Care until three days later.

A Critical Incident Report revealed an incident of alleged abuse concerning a staff member towards a resident. This incident was reported by the resident to the Registered Practical Nurse (RPN). This incident was not reported to the Ministry of Health and Long Term Care until one day later.

A review of the home's Abuse and Neglect of Residents policy revealed it was mandatory that any alleged, witnessed or suspected abuse or neglect of a resident be reported immediately, based on the requirements of the LTC Homes Act 2007.

An interview with the Director of Care confirmed the dates of the critical incidents and progress notes and confirmed that it was the home's expectation that the policy for Abuse and Neglect of Residents be complied with. [s. 20. (1)]

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 there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident monitoring and internal reporting protocols were in place for residents with responsive behaviours.

A record review revealed a Resident had been exhibiting a behaviour since early 2015.

A Resident was observed in another Resident`s room exhibiting a behaviour.

The Resident reported to staff that the co-resident was making the resident feel uncomfortable.

Behavioural Support Ontario (BSO) added every 30 minute safety checks to the plan of care for both resident`s.

A review of documentation revealed no safety checks had been completed for one of the resident`s.

An interview with the Director of Care revealed no resident monitoring had been completed on the Resident for four days although the critical incident had been reported for alleged abuse in that time.

The Director of Care confirmed it was the homes expectation that both residents should have received safety check monitoring as a result of the incident. [s. 53. (1) 3.]

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 resident monitoring and internal reporting protocols were in place for residents with responsive behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after the occurrence of a medication incident in respect of which a resident was taken to hospital.

A record review revealed a Resident was admitted to a hospital as the resident had a change in condition and later returned to the home.

Eight controlled substances were discovered in a Resident room by registered staff. The licensee conducted an investigation.

Later nine controlled substances were observed in the Resident room.

Records confirmed the resident had been admitted to the hospital following an incident. This information was then shared with the Administrator.

A Critical Incident Report was not submitted to the Ministry of Health and Long Term Care until eight days later.

An interview with the Director of Care confirmed it was the home's expectation that the licensee should inform the Director no later than one business day after the occurrence of a medication incident in respect of which a resident was taken to hospital. [s. 107. (3)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.