Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128), MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2014_182128_0001
Log No. / Registre no:	L-000677-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 10, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CARE, LONDON 268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2
LTC Home / Foyer de SLD :	ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S 21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6
	ANN WOUTERS

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To ST. JOSEPH'S HEALTH CARE, LONDON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_182128_0009, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must ensure that all staff are aware of policies related to pain management, skin and wound care, medication storage, abuse and neglect and education is provided to all staff related to these policies.
Please ensure that documentation is kept to demonstrate that all staff have received the education.

Grounds / Motifs :

1. The licensee failed to ensure that all plans put in place and specifically the compliance plan submitted to the Ministry, in response to a previously identified Compliance Order, was complied with, as evidenced by:

Order #001, was issued June 26, 2014 related to the home not having policies and procedures in compliance with legislation and/or not complying with the home's policies.
The order indicated that all staff must be provided education on the policies. The home submitted a compliance plan July 16, 2014 and amendment July 23, 2014 which indicated that all staff were to receive education related to Abuse Prevention and Reporting through an e-learning module. The deadline for completion was August 31, 2014.
Education records were reviewed and they revealed that 27/231 staff (12%) have not completed the e-learning module.

The Director acknowledged that all staff have not completed the education as per the compliance plan submitted to the Ministry. (128)

2. A. The licensee failed to ensure that the Medication Refrigerators Policy was complied with, as evidenced by:

A review of the policy entitled Medication Refrigerators, revised August 2014, revealed it was not being complied with as the policy indicated that medication refrigerators are to be kept clean and used only to store medications and products related to medication administration or treatment of residents. e.g. food items for managing hypoglycemia (honey, soda). Food other than that used for medication administration must never be stored in the medication fridge (e.g. staff lunches).

An observation of a medication refrigerator revealed a container of food being stored on the bottom shelf.
Two Registered Staff members confirmed it was a staff lunch being stored in the medication fridge and shared the expectation is that staff lunches should not be stored there.

B. The licensee failed to ensure that the policy Skin Care & Assessment and Wound Management was complied with, as evidenced by:

A review of the policy entitled Skin Care & Assessment and Wound Management, revised July 2014, revealed it was not being complied with as the policy indicated:
(a) # 19. The nurse must refer all identified Stage II, III, IV and X pressure wounds, as well as skin tears, to the dietitian for follow-up, by completing "Referral to Dietitian" Progress Note in the electronic documentation system.
A review of the clinical record for resident # 12 revealed the presence of a wound and no documented evidence that a referral was made to the RD related to impaired skin integrity.

An interview with the RD confirmed there was no referral made related to impaired skin integrity, as well as the expectation that a referral be made.

(b) The policy also indicated wound care is provided by the RN/RPN. The nurse providing the care assesses the wound weekly and documents weekly on the Wound/Skin Assessment in the electronic documentation system.

A review of the weekly wound assessments for resident # 14 revealed there was no weekly wound assessment completed on a specified date. The resident has a Stage III and Stage X wound.

An interview with a Registered Staff member confirmed the weekly wound assessment was not completed on and the expectation is that weekly wound assessments be completed.

C. The licensee failed to ensure that the Pain Assessment and Management policy was complied with, as evidenced by:

A review of the policy entitled Pain Assessment and Management Of, revised July 2014, revealed it was not being complied with as the policy indicated:
6. Pain management interventions are recorded on the Plan of Care for the resident.
A record review revealed there was no documented evidence that pain management interventions were recorded on the Plan of Care for resident # 15.

An interview with a Registered Staff member confirmed pain management interventions were not recorded on the plan of care for resident # 15, as well as the expectation that the presence of pain and interventions be recorded on the plan of care. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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

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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 10, 2014	2014_182128_0001	L-000677-14	Follow up

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 - ST. MARY'S
21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6

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

RUTH HILDEBRAND (128), MARIAN MACDONALD (137)

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): September 26 & 29, 2014

During the course of the inspection, the inspector(s) spoke with the Director, Coordinator Resident Care, Administrative Assistant, Registered Dietitian (RD), Coordinator Food and Nutrition, 3 Registered Nurses, 4 Registered Practical Nurses, 9 Personal Care Providers (PCP) and 2 Housekeepers.

During the course of the inspection, the inspector(s) observed a lunch meal as well as residents eating in their rooms, medication refrigerators and posted information, reviewed relevant policies and procedures, auditing processes, as well as clinical records of identified residents and staff education records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. A. The licensee failed to ensure that the Medication Refrigerators Policy was

complied with, as evidenced by:

A review of the policy entitled Medication Refrigerators, revised August 2014, revealed it was not being complied with as the policy indicated that medication refrigerators are to be kept clean and used only to store medications and products related to medication administration or treatment of residents. e.g. food items for managing hypoglycemia (honey, soda). Food other than that used for medication administration must never be stored in the medication fridge (e.g. staff lunches).

An observation of a medication refrigerator revealed a container of food being stored on the bottom shelf.
Two Registered Staff members confirmed it was a staff lunch being stored in the medication fridge and shared the expectation is that staff lunches should not be stored there.

B. The licensee failed to ensure that the policy Skin Care & Assessment and Wound Management was complied with, as evidenced by:

A review of the policy entitled Skin Care & Assessment and Wound Management, revised July 2014, revealed it was not being complied with as the policy indicated:
(a) # 19. The nurse must refer all identified Stage II, III, IV and X pressure wounds, as well as skin tears, to the dietitian for follow-up, by completing "Referral to Dietitian" Progress Note in the electronic documentation system.
A review of the clinical record for resident # 12 revealed the presence of a wound and no documented evidence that a referral was made to the RD related to impaired skin integrity.

An interview with the RD confirmed there was no referral made related to impaired skin integrity, as well as the expectation that a referral be made.

(b) The policy also indicated wound care is provided by the RN/RPN. The nurse providing the care assesses the wound weekly and documents weekly on the Wound/Skin Assessment in the electronic documentation system.
A review of the weekly wound assessments for resident # 14 revealed there was no weekly wound assessment completed on a specified date.

An interview with a Registered Staff member confirmed the weekly wound assessment was not completed and the expectation was that weekly wound

assessments be completed.

C. The licensee failed to ensure that the Pain Assessment and Management policy was complied with, as evidenced by:

A review of the policy entitled Pain Assessment and Management Of, revised July 2014, revealed it was not being complied with as the policy indicated:
6. Pain management interventions are recorded on the Plan of Care for the resident.
A record review revealed there was no documented evidence that pain management interventions were recorded on the Plan of Care for resident # 15.

An interview with a Registered Staff member confirmed pain management interventions were not recorded on the plan of care for resident # 15, as well as the expectation that the presence of pain and interventions be recorded on the plan of care. [s. 8. (1) (b)]

2. The licensee failed to ensure that all plans put in place and specifically the compliance plan submitted to the Ministry, in response to a previously identified Compliance Order, was complied with, as evidenced by:

Order #001, was issued June 26, 2014 related to the home not having policies and procedures in compliance with legislation and/or not complying with the home's policies.
The order indicated that all staff must be provided education on the policies. The home submitted a compliance plan July 16, 2014 and amendment July 23, 2014 which indicated that all staff were to receive education related to Abuse Prevention and Reporting through an e-learning module. The deadline for completion was August 31, 2014.
Education records were reviewed and they revealed that 27/231 staff (12%) have not completed the e-learning module.
The Director acknowledged that all staff have not completed the education as per the compliance plan submitted to the Ministry. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques to assist residents with eating, including safe positioning of residents who required assistance were provided for all residents, as evidenced by:

On September 26, 2014, resident #2 was observed being assisted with eating lunch in bed. The resident was not at a safe feeding height with the bed height being at approximately a 65 degree angle. The resident had fluid running out of his/her mouth and down the face. The resident was also coughing.
After MOHLTC intervention, the Personal Care Provider changed the height of the bed to 90 degrees and stated that the resident should have been positioned at a 90 degree angle to ensure safe positioning.
The Personal Care Provider assisting the resident indicated that he/she was unsure if the resident was at risk of choking.
The Personal Care Provider acknowledged that the resident was not safely positioned and that the resident was coughing and had fluid running from the mouth.

The Coordinator, Resident Care confirmed the expectation was that residents were seated in an upright position, at 90 degrees, to ensure safety while being assisted with eating, including while in bed. [s. 73. (1) 10.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance, as evidenced by:

Resident #3 was observed in a dining room, with an entrée sitting in front of him/her, for 8 minutes before a staff member came to assist the resident with eating.
A Personal Care Provider indicated that it was current practice to provide residents with meals even if someone wasn't available to assist them with eating.
The Coordinator, Resident Care stated that the home's education related to dining informed staff that the meal could sit in front of a resident for up to 5 minutes before assistance was provided.
The Director and the Coordinator, Resident Care indicated that they were not aware that this had changed with the implementation of the Long-Term Care Homes Act and Regulations, in July 2010. [s. 73. (2) (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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance is provided for all residents, to be implemented voluntarily.

Issued on this 10th day of October, 2014

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