



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**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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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 13, 2015	2015_228172_0001	009617-14	Complaint

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### **Licensee/Titulaire de permis**

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

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### **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

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

JOAN WOODLEY (172), CHAD CAMPS (609)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 6, 7, 2015**

**During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care, 2 Directors of Resident Care, 1 RAI-Coordinator, 1 Registered Nurse, 3 Registered Practical Nurses, 1 Primary Care Providers ( PCP ), 1 Occupational Therapist and a specific Resident.**

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

**Continence Care and Bowel Management**

**Pain**

**Personal Support Services**

**Skin and Wound Care**

**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**

<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>Legendé</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. 6.  
Plan of care**

**Specifically failed to comply with the following:**

- 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,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**



**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Care plan review for a specific Resident revealed no focus, no goals and no interventions specific to pain, even though receiving an analgesic routinely for pain.

Interview with a member of the registered staff confirmed there was no focus of pain on the care plan and shared it is the home's expectation that pain would be addressed in the care plan.

2. Care plan review for another Resident revealed staff were to clean this resident's mouth and tongue each morning, evening and after meals

Interview with a member of the registered staff confirmed the care plan gave direction to provide oral care 5 times a day.

Interviews with a PCP and registered staff revealed mouth care is provided in the morning and the evening.

Interview with a member of the registered staff confirmed the home's expectation is that mouth care would be provided to residents in the am and pm unless otherwise required.

3. Care plan review for a specific resident revealed a behaviour with goals and interventions.

Interviews with a PCP and a member of the registered staff revealed this behaviour is no longer present.

Chart review revealed this resident has not demonstrated this behaviour in excess of 6 months.

Interview with a registered staff confirmed the care plan was outdated and the home's expectation is that when care plans are reviewed quarterly or when there is a change in a resident's condition that the care plan be revised and be reflective of the resident's care needs [s. 6. (1) (c)]



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***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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**Issued on this 13th day of January, 2015**

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

**Original report signed by the inspector.**