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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 16, 2015 | 2015_183135_0024 | 009916-15 | 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 - 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

BONNIE MACDONALD (135)

### 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): June 9, 10, 11, 2015.**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Resident Care Coordinator, Registered Nurse, Registered Practical Nurses, Personal Care Providers, Family Member and Resident.**

**During the course of the inspection, the inspector(s) reviewed resident clinical records and policy and procedures. Observed resident care and services provided in resident home area.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

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

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that the resident was reassessed and the plan of care revised when care set out in the plan has not been effective, and that different approaches be considered in the revision of the plan of care when the following occurred:

Record review on June 9, 2015, revealed Resident #002 had been experiencing increasing responsive behaviours.

Record review revealed there were 33 documented incidents when the resident had responsive behaviours related to other residents.

In interviews with nursing staff June 9, 2015, they reported that the resident has ongoing responsive behaviours. Other residents also reported ongoing resident behaviours.

During an interview with the home's Behavioural Supports Ontario (BSO) staff members June 9, 2015, staff revealed that resident #002 had been on their caseload for "quite a while."
Record review revealed since November 2014, the BSO team had assessed the resident once for ongoing escalating behaviours.

Review of resident #002's plan of care on June 9, 2015, revealed that the care plan had not been revised since March 24, 2014, nor were different approaches considered when interventions were not successful for the resident's ongoing behaviours.

During an interview the Resident Care Coordinator confirmed her expectation that residents are reassessed for ongoing responsive behaviours and that the care plan be revised when care set out in the plan has not been effective, and that different approaches be considered in the revision of the plan of care. [s. 6. (11) (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 ensuring that the resident is reassessed and the plan of care revised when care set out in the plan has not been effective, and that different approaches be considered in the revision of the plan of care, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure the residents' plan of care was based on an interdisciplinary assessment of the resident's responsive behaviours that included the following:
• any mood and behaviour patterns, including wandering
• any identified responsive behaviours
• any potential behavioural triggers and variations in resident functioning at different times of the day when the following occurred:

Record review on June 9, 2015, revealed Resident #002 had been experiencing ongoing increasing responsive behaviours.

In interviews with nursing staff June 9, 2015, they reported that the resident has had an increase in behaviours.

Record review revealed there were 33 documented incidents related to responsive behaviours for Resident #002.

Record review of the resident's plan care revealed that the last time the care plan had been updated for responsive behaviours was March 24, 2014.

Record review of Resident #002's plan of care as of June 8, 2015, revealed the plan did not include an assessment of mood and behaviour patterns, nor did it include responsive behaviours and potential triggers and variations in resident functioning at different times of the day for responsive behaviours.

During an interview the Resident Care Coordinator confirmed her expectation that the resident's plan of care is based on an interdisciplinary assessment of the resident's responsive behaviours that includes, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 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 ensuring that the resident's plan of care is based on an interdisciplinary assessment of the resident's responsive behaviours that include, mood and behaviour patterns, identified responsive behaviours and potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

---

**Issued on this 16th day of June, 2015**

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

**Original report signed by the inspector.**