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 prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 05, 2015;	2014_182128_0009 (A4)	L-000546-14	Resident Quality Inspection

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

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DONNA TIERNEY (569) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

This inspection report and order report have been changed to extend the compliance date for Order #002 related to Administrator hours to January 1, 2016.

Issued on this 5 day of August 2015 (A4)

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

Original report signed by the inspector.

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

DONNA TIERNEY (569) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 13-16, 20-23 & 26, 2014

This inspection was done in conjunction with two Follow-up inspections, Log # L-000843-13 and L-000631-14.

During the course of the inspection, the inspector(s) spoke with the Vice-President of Complex, Specialty Aging and Rehabilitative Care (Vice President), 2 Coordinators of Resident Care, Administrative Assistant, Coordinator of Nutrition Services, 2 Nutrition Managers, Coordinator of Facilities Engineering, Coordinator of Environmental Services, Staff Educator, RAI Coordinator, Social Worker, Coordinator Volunteer Services, 2 Infection Prevention and Control Nurses, Team Assistant, Physiotherapist, 2 Therapeutic Recreation Assistants, 3 Registered Nurses(RN), 12 Registered Practical Nurses(RPN), 24 Personal Care Providers (PCP), 1 Private Duty Care Provider, 5 Food Service Workers, 3 Housekeepers, Seamstress, Resident Council and Family Council Representatives, 6 Family Members and 40+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident home, dining and common areas, and medication storage areas. The Inspectors observed resident care, resident-staff interactions, dining service, and recreational activities. Relevant clinical records, home policies, procedures and meeting minutes were reviewed. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Skin and Wound Care

Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 24. (1)	CO #001	2014_228172_0001	128

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, as evidenced by:

A review of the home's policy, entitled Skin Care and Assessment and Wound Management, Revised November 2013, indicated:
Wound Identification and Care, #22 - Wound care is provided by the RN/RPN on the shift the care is assigned to. The nurse providing the care assesses the wound weekly - the assessment finding and current treatment are documented weekly on the "Wound/Skin Assessment" in the electronic documentation system; this assessment includes evaluation of the current plan of care, including dietary measures, etc.; documentation must occur more often than weekly if the wound is rapidly changing.
A review of Weekly Wound/Skin Assessments revealed that the assessments were not consistently being conducted weekly for 3 residents:
a. Resident # 111 - There were 18 days between the initial wound assessment and the next assessment done.

b. Resident # 123 - There were 28 days between the initial wound assessment conducted and the next assessment done.

c. Resident # 142 - Four assessments were not completed weekly and the time frames in-between were 11 days, 14 days and two were 17 days.

Three Registered Practical Nurses confirmed that the expectation was that assessments were completed weekly and that the home's policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the skin and wound care policy instituted was in compliance with and implemented in accordance with applicable requirements under

the LTCHA/Regulations, as evidenced by:

A review of the policy, Skin Care and Assessment and Wound Management, revised November 2013, indicated:
Wound Identification and Care, #19 - The nurse refers all identified Stage II, III, IV and X wounds to the dietitian for follow-up, by completing a "Referral to Dietitian" Progress Note in the electronic documentation system. Skin tears are also referred to the dietitian if healing is delayed.

The Regulations require that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian.

Review of the clinical record for Resident # 111 indicates that the resident sustained a skin tear during dressing. The clinical record does not indicate that a dietitian assessment was completed.
A Registered Practical Nurse confirmed that referrals were made only when wounds were assessed as a stage 2 or more severe.

The Coordinator of Resident Care acknowledged that the home's policy on skin and wound management was not in compliance with the Regulations as it did not include that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the policy related to medications was in compliance with and implemented in accordance with applicable requirements under the LTCHA/Regulations, as evidenced by:

A review of the home's policy entitled Medications from Home, revised date of April 2014, revealed that it states "if the physician has authorized the medications, but there is a delay in the drugs being sent to the unit, registered staff may administer the resident's own supply, in order to avoid the resident not getting needed medications. The nurse must document administration of the medications in the eMAR if the medications appear there, or in the Progress Notes using the "eMAR - Medication Administration".

The Regulations indicate no drug is acquired, received, or stored by or in the home or kept by a resident unless the drug has been provided by, or through an arrangement

made by, the pharmacy service provider or the Government of Ontario. This does not apply where exceptional circumstances exist such that a drug prescribed for a resident cannot be provided by, or through an arrangement by, the pharmacy service provider.

A clinical record review for Resident #022, revealed the doctor signed an order for a medication. However, the pharmacy did not supply this medication for the resident.
A Registered Practical Nurse stated that the resident's personal supply of the medication was opened and had two different medications in the bottle and the RPN was unsure of what either medication in the bottle was.
The Coordinator of Resident Care acknowledged that the medication from home should not have been used and that the home's policy was not in compliance with the Regulations. [s. 8. (1)]

4. The licensee failed to ensure that the medication policy was complied with, as evidenced by:

Review of the home's policy entitled "Storage of Medications", revised April 2014, revealed medication requiring refrigeration was to be stored in the unit medication refrigerator, physically separate from food products such as applesauce used for medication administration. The policy further indicated other food used for medication administration was never to be stored in the medication fridge.
A medication room refrigerator contained two unopened yogurts, one open can of ginger ale and one open bottle of Coca Cola.

A Registered Practical Nurse stated the small fridge was used to store medication and that another larger fridge was available to store staff and resident food. The Registered Practical Nurse stated she did not know that food couldn't be stored in the medication fridge.

The Coordinator of Resident Care verified that no food or drinks were to be stored in the medication fridges in the medication rooms and the expectation was that food and drinks belonging to the residents and staff were to be kept in designated fridges outside of the medication rooms. [s. 8. (1)]

5. The licensee failed to ensure that the Resident Weights policy was complied with, as evidenced by:

A review of the policy entitled Resident Weights, revised November 2013, revealed

that it was not being followed as the policy indicated that all residents were to be weighed at least monthly.
All residents were to be weighed by the PCP during the first week following their admission to Mount Hope.

A review of the Monthly Weight Report, on May 21, 2014, revealed 80 of 173 residents in the home (46%) were not weighed according to the home's weight policy. It was noted that 23 residents were not weighed, within the first week of the month as they were not weighed as of May 21, 2014.
All residents were not weighed monthly as noted between November 2013 to current:
34 residents had no weights recorded for one month;
17 residents had no weights recorded for two months;
14 residents had no weights recorded for three months;
3 residents had no weights recorded for four months;
3 residents had no weights recorded for five months.
Additionally, a review of the clinical records for two of three respite admissions (66.6%) revealed that they had not been weighed upon admission.

The Registered Dietitian acknowledged that weights are not done on a monthly basis for all residents.

The Coordinator of Resident Care and the Vice President stated that the expectation was that the weight policy was followed. [s. 8. (1) (a),s. 8. (1) (b)]

6. The licensee failed to ensure that the pain assessment and management policy was complied with, as evidenced by:

A review of the policy Pain: Assessment and Management, revised November 2013, indicated the following:
All residents are assessed on admission for the presence of pain.
All residents are assessed, re-assessed quarterly for the presence and quality of pain, as well as whenever there is a change in the health status which has the potential to precipitate pain, using the Pain Assessment tool in the electronic documentation system.
All residents at risk for pain are screened for pain at least once a day.
Pain management interventions are recorded on the Plan of Care and the existence of and management of pain is also recorded in the resident chart.
Tools which may be used to evaluate pain include but are not limited to pain rating scales, including face scales and the Pain Assessment tool in the electronic

documentation system.
Residents are also fully re-assessed at each new occurrence of pain (e.g. new site).
Unexpected or intense pain, especially of sudden onset, must be immediately evaluated by the RN.
Nurses evaluate residents after every individual administration of interventions for pain.

A review of progress notes for Resident #016 revealed 18 documented entries in a 14 week period where the resident expressed pain and required an analgesic.

A registered nurse confirmed a pain assessment was not completed and the policy was not complied with. [s. 8. (1)]

7. The licensee failed to ensure that the Feeding and Supervision of Residents Who Are Eating policy was complied with, as evidenced by:

A review of the policy Feeding and Supervision of Residents Who Are Eating, revised October 2013, indicated:
#6. For residents who are eating in their room during a meal (due to isolation, etc.): Supervision must still be provided to ensure the resident is eating safely.
If the resident is accompanied by a responsible adult (e.g. family member), the resident may be supervised by that person; unit staff must ensure this person is educated about the resident's dietary needs and restrictions, as well as any known risks to the resident e.g. known choking risk.
If the resident has no one with them, staff need to provide at least intermittent supervision if the resident is not at choking risk.

Resident # 011 was observed in bed with a breakfast tray on the bedside table, with the main meal uncovered and all containers opened.
It was confirmed by a Personal Care Provider and a Registered Staff that it was the expectation that all residents were to be monitored if eating in their room and the level of supervision was based on identified needs. It was confirmed that this resident was not a choking risk and required intermittent supervision during eating.

A PCP confirmed that the resident was not checked after the tray was delivered and was not supervised during meal service, as required by the policy.

The Coordinator of Resident Care and the Vice President acknowledged the expectation was that all residents were monitored during eating. [s. 8. (1) (b)]

8. The licensee failed to ensure that the Abuse policy was complied with, as evidenced by:

A review of the policy Abuse and Neglect of Residents - Zero Tolerance - Revised April 2014
indicated the following:
6 -When an incident of alleged, witnessed or suspected abuse of a resident occurs, causing harm or the potential for harm to that resident, the person who becomes aware of the abuse must report the incident immediately to the RN who will in turn notify....
In the evening, at night or on week-ends, the building Registered Nurse informs the Ministry by calling 1-866-414-0013. Provide the resident's name and specific details about the incident. The RN is to notify the Clinical-on-Call. Include all such incidents on 24-hr. summative report, so the Coordinator can follow up.

The policy was not followed in two instances of alleged abuse:

a. Resident #012 reported to a Registered Practical Nurse that he/she had been a victim of alleged emotional abuse by a Personal Care Provider several weeks before in his/her bedroom.

The Registered Practical Nurse failed to report the alleged abuse to the Registered Nurse as per the home's abuse and neglect policy.

The Coordinator of Resident Care verified the home's abuse policy was not followed.

b. During a resident and family interview, it was revealed that between March - April, 2014, date not confirmed, an incident of alleged, suspected or witnessed abuse was reported to a Registered Nurse.
The Coordinator of Resident Care confirmed the Registered Nurse did not inform the Ministry, did not notify the Clinical-on-Call, the incident was not included on the 24 hour summative report, for follow-up by the Coordinator and the home's policy was not complied with. (137) [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. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had an Administrator who worked regularly in that position, on site at the home, for at least 35 hours per week.

There is one full-time Administrator (Director) for Mount Hope Centre for Long Term Care, which encompasses two long-term care homes; Marian Villa and St. Mary's. St. Mary's has a capacity for 177 residents and Marian Villa has a capacity for 217 residents.
Although there is some administrative support from a St Joseph's Health Care, London Vice-President and a number of other St. Joseph's employees, there is not another 35 hours per week, on site in the home, in the position of Administrator.

Therefore, Mount Hope (St. Mary's) does not have an Administrator (Director) who works regularly on site in the home for at least 35 hours per week.

This was confirmed by the Vice-President of Complex, Specialty Aging and Rehabilitative Care. [s. 212. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary, as evidenced by:

Observations, related to lack of housekeeping were noted throughout the RQI.
Dining rooms:
Five of five feeding stools(100%), in the first floor dining room were soiled with a build-up of crumbs and drips on them. Additionally, thirteen of thirteen dining room chairs (100%) were noted to have stains, pieces of dried food, and drips on them. The first floor dining room linen cart was soiled with red food spills and black debris.
There was a build-up of black/brownish debris at the edge of all the walls, on the baseboards, as well as on the stove, the under counter refrigerator and at the base of

the hand sink, on the serving counter in the first floor dining room. The slatted metal blinds on the interior dining room windows were observed to have a build-up of food on them and the strings were also noted to be dirty. (128)

Dried food was observed on six of seven dining room chairs (86%), in the second floor dining room.

Dried food was observed on the base board, underneath the bulletin board, in the third floor dining room.

Carpets throughout the home were observed to be stained and unclean.

In the Bathing Suite, #X224, the shower curtain around the toilet was dirty/stained at edge near the sink at the top of the curtain. The floor at the seam of the shower was stained and/or had a white coloured film on it.

The Coordinator of Environmental Services confirmed the identified deficiencies and shared the expectation was that the the home, furnishings and equipment were kept clean and sanitary.
(105),(128), (517), (537) [s. 15. (2) (a)]

2. The licensee failed to ensured that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, as evidenced by:

Observations, throughout the RQI, revealed :

First Floor resident rooms
-The wall thermostat was missing a cover and the baseboard was missing at the bathroom door wall. Closet doors were scraped and had black scuff marks on them.
-There were black scuff marks on the baseboard and the closet wall of the room.
- The baseboard was missing at the bathroom door. Wall closet doors were scraped and had black scuff marks on them.
- There was dried debris on the wall and the baseboard under the the TV desk. The cork board, on the wall, was scraped.
- There was dried food, as well as paint, on the arm rests of the chair. The door to the resident room was scraped from mid door to the floor. The door frame to the bathroom was damaged with scrapes and chipped paint.

Second Floor resident rooms

- The chair rail was damaged outside the room.
- Five bedroom doors were damaged and had black marks on them.
-There was damage to the paint on the wall outside of a room .
- There were black marks on the wall of the room next to the bathroom and wall of the bathroom beside the toilet.
- There were scrapes on the wall behind the brown comfortable chair. The wall was damaged outside the bathroom door next to the bed and the bedroom door was scraped.
- The carpet had a large stain beside the bed and was stained at the entrance to the room.
- The door of the bathroom had chips in it. The wall at the foot of the bed had wallpaper that was damaged/ ripped. The baseboard in the room had black marks on it and the black office chair had a build up of a brown substance as well as white substance on it. The door to room had the wood chipped and the door frame was scraped and had paint chipped off. The threshold between bathroom door and carpet had duct tape on it and the wall above bathroom sink had 3 spots where paint had peeled off of it.
Shower room #V216- Walls were damaged on both sides of the entrance. The paint was peeling and the baseboard was coming off the wall.
W215 - Bathing Suite - The floor had black stains on it as well as water stains on both sides of tub. The door to the room was scraped and had black marks on it. The door frame was scraped and paint chipped and the tub had black marks/scrapes on it. The ceiling vent had a build up of dust on it.
- There were black marks on the baseboards in the common areas of 2nd floor, under the window with the tomato plants in it.

Third Floor
The servery area door was damaged, in the dining room.
The wall, to the right of the servery door entrance, was damaged.
W313 – The bathing Suite door was damaged and the door frame had chipped paint.
X322 – The bathing Suite door was damaged, the door frame had chipped paint and the wall, to the left of the entrance, had chipped paint.
X319 – Shower walls were damaged, as well as the paint peeling and chipped on all walls.
Throughout the hallway, walls were damaged and/or scratched below the hand rails and above baseboards.
V320 - Shower room walls were damaged and paint peeling.
V303 - TV Lounge - the lower portion of the wooden door was damaged and black

marks noted.
-Six bedroom doors were damaged and had black marks on them.

Fifth Floor
Stairwell 5X - the ceiling behind the exit sign, revealed water damage, which appeared to still be wet and plaster tape hanging down from it.
X524 - Lounge - A call bell was loose in the wall. The call bell was checked and was working.
The hallway wall, to the right of the dining room entrance door, was damaged.
(105),(128), (517), (537) [s. 15. (2) (c)]

3. Weeds were noted to be growing on the 1st and 2nd floor dining room balconies.
(128) [s. 15. (2) (c)]

4. Observations of the third floor resident/family laundry room, by Inspectors # 128 and 137, revealed a washing machine containing stagnant water, with a mold-like film substance on top of the water.
A sign on the door indicated not to use the washing machine as parts were on order.
A Registered Practical Nurse confirmed the laundry room was accessible to residents/family members and a maintenance request was submitted on April 1, 2014, identifying that the washing machine was not working.

The Coordinator of Facilities Engineering acknowledged that the expectation was that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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, furnishings and equipment are kept clean and sanitary and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: 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 failed to ensure the long-term care home was equipped with a resident-staff communication and response system that was easily seen, accessed and used by residents, as evidenced by:

The call bell for Resident #025 was observed to be caught behind the bed and not accessible to the resident.
A PCP confirmed that call bell was stuck behind the bed and immediately pulled the bed out to make the call bell accessible.
The Coordinator of Resident Care acknowledged that the expectation was that call bells were within reach of residents at all times. [s. 17. (1)]

2. The licensee failed to ensure the long-term care home was equipped with a resident-staff communication and response system that was on at all times as evidenced by:

A non-functioning call bell was observed, in the washroom of Resident #123. When the inspector tested the call bell by pulling the string, the call bell was not on and/or did not alert staff.

The non-functioning call bell was reported to a Registered Practical Nurse who indicated that maintenance would be notified to ensure it was fixed immediately.

The Registered Practical Nurse and the Coordinator of Resident Care verified the resident-staff communication and response system in the resident's washroom was to be on and functioning at all times. [s. 17. (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 call bells can be easily seen, accessed and used by residents at all times and that the communication and response system is on at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, as evidenced by:

Review of the clinical record for Resident # 111 indicated that the resident sustained a skin tear during dressing. The clinical record did not indicate that a dietitian assessment was completed.

A Registered Practical Nurse confirmed the resident was not assessed by the dietitian and a referral was not made. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

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

a. Resident # 020 was observed being assisted with drinking, by a visitor, in a dining room. The visitor was standing to assist the resident who was positioned at approximately a 78 degree angle, placing the resident at potential choking risk.
The visitor and a Registered Practical Nurse acknowledged that the resident was not in a safe eating position and stated that the resident was on a pureed texture related to choking.
A clinical record review revealed that the resident was at risk of aspiration related to dysphagia.

b. A private care provider, was observed, in a dining room, standing to provide beverages to Resident #024, placing the resident at potential choking risk.
The private care provider acknowledged that she should have been sitting as standing to feed the resident would place the resident at potential choking risk.
A Registered Practical Nurse, indicated that the expectation was that everyone should sit to feed residents so that they were not placed at choking risk.

The Coordinator of Resident Care and the Vice President indicated that the expectation was that residents were positioned safely while being assisted with eating.
[s. 73. (1) 10.]

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 with eating are utilized by all staff, volunteers and visitors to the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services, the licensee failed to ensure that, there were schedules and procedures in place for routine, preventive and remedial maintenance, as evidenced by:

There was no documented evidence that there were schedules and procedures in place for routine, preventive and remedial maintenance, specifically related to painting and damaged walls/doors.

The Coordinator of Facilities Engineering confirmed there were no schedules and procedures related to painting and damaged walls/doors and the expectation was there should be schedules and procedures in place. [s. 90. (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,as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, as evidenced by:

During the initial tour of the home, on May 13, 2014, hazardous substances were found accessible to residents in three locations:
Bathing Suite X522 was found unlocked with Neutral Disinfectant cleaner in the room. This was verified by a PCP who removed the chemicals and the door was locked by another PCP.
Shower room V420 was found propped open with a bottle of Neutral Disinfectant cleaner in the room. A PCP verified this and locked the door.
Storage Room X412 was found with the door wide open and a bottle of disinfectant stored on the bottom shelf. A PCP verified that the chemicals were there and secured the room.

The expectation, confirmed by the Coordinator of Resident Care, was that all doors where chemicals are stored, should be locked. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every complaint had a documented record kept, as evidenced by:

A clinical record review and resident interview revealed that Resident #108 reported missing money to staff.
A review of the Mount Hope Resident Complaints binder revealed that there was not a documented record of actions taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.
The Coordinator of Resident Care confirmed that the record had not been filled out.
The Vice President stated that the expectation was that the a documented record was to be initiated upon receiving a complaint. [s. 101. (2)]

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 a documented record of all complaints is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area that was secure and locked, as evidenced by:

A medication room door was observed open. No registered staff member was in close visual proximity and medications were on top of the medication cart.

A Registered Nurse confirmed the observations.
The Registered Nurse indicated the expectation was that the medication room door was to be closed and locked, at all times, when a registered staff member was not present. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program, as evidenced by:

A resident tray was observed being taken to a resident room for lunch service with glasses of fluids not covered.

The Coordinator of Nutrition Services indicated that the home did not have a policy related to carrying uncovered fluids down the hall, on trays, but acknowledged the infection control risk and indicated that the home needed to address this issue. (128) [s. 229. (4)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection control program with regard to hand hygiene, as evidenced by:

a. A Personal Care Provider was observed removing dirty dishes from resident tables in the dining room, on 1st floor, and then serving dessert without performing hand hygiene.

It was confirmed by the Personal Care Provider that hand hygiene should have occurred after the removal of dirty dishes before serving food to the residents.

b. A Registered Practical Nurse did not perform hand hygiene/hand washing before handling or administering medications to two residents.

The Coordinator of Resident Care and the Registered Practical Nurse revealed the expectation was that hand hygiene was performed prior to the handling and administration of medications to residents. [s. 229. (4)]

3. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program, as evidenced by:

The following unlabelled or improperly stored personal care items were observed in shared resident washrooms May 13-15, 2014:

- two unlabelled stainless steel k-basins containing three unlabelled toothbrushes, an unlabelled comb on the counter and an unlabelled denture cup, as well as an unlabelled wash basin on the counter.

- an unlabelled k-basin as well as three unlabelled toothbrushes.

- two unlabelled bed pans on the towel rack behind the toilet, one unlabelled care caddy containing an unlabelled toothbrush,and an unlabelled bar soap container with a bar of soap in it.

- an unlabelled bedpan stored behind the grab bar at the back of the toilet, an

unlabelled toothbrush, comb, nail brush and denture cup.

- a graduated cylinder, used for measuring output, was on the back of the toilet.

- 2 wash basins in the bathroom.

Bathing Suite W115 - five used deodorant sticks were found in an orange bucket in a cupboard and 4 of them were not labelled.
A Registered Practical Nurse shared they should have been labelled for each resident and verified they were not. She destroyed the 4 unlabelled deodorant sticks.

One Personal Care Provider stated that bed pans and wash basins were stored in resident washrooms so that the housekeepers could clean them.
Another Personal Care Provider and two Registered Practical Nurses confirmed the personal items were not labeled and not stored properly. They shared the expectation was that all personal items were to be labeled in shared washrooms and bedpans, etc. were to be stored in the soiled utility room, when not in use.
The Coordinator of Resident Care acknowledged the expectation that all personal care items in shared washrooms were to be labelled and properly stored. [s. 229. (4)]

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 all staff participate in the implementation of the infection control program as it relates to tray service, hand hygiene and labelling and storage of personal care items, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have his or her participation in decision making respected, as evidenced by:

Resident #100 was observed lying in bed while the other residents on the floor were in the dining room for breakfast. When interviewed the same morning, the resident stated he/she attended the dining room for the majority of meals as per his/her wishes. The resident further reported one Personal Care Provider told him/her earlier that morning she did not have time to take him/her to the dining room for breakfast and that happened several times before, also.

A health record review for Resident #100 revealed the resident was totally dependent on staff assistance for transfers and locomotion on the unit.

Three Personal Care Providers verified they were aware Resident #100 wished to go to the dining room for all meals, including breakfast. One Personal Care Provider further indicated she/he told the resident she/he did not have time to take him/her to the dining room for breakfast that morning and that happened several times before.

The Coordinator of Resident Care revealed the expectation was that Personal Care Providers were to take Resident #100 to the dining room for all meals including breakfast, as per his/her plan of care and his/her wishes. The Coordinator of Resident Care further verified the expectation was that all direct care staff respect the resident's right to participate in decision-making. [s. 3. (1) 9.]

2. The licensee did not ensure residents had their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, as evidenced by:

The door to a Coat Room was observed open and unattended. Inside the room there were laboratory swabs, other specimen collection supplies, as well as lab forms with resident names and medical information on them.

A Registered Practical Nurse confirmed that the room was being used to store laboratory supplies and that the registered staff had a key to the room.

The Registered Practical Nurse and the Coordinator of Resident Care confirmed the door to room W231 was to be kept closed and locked at all times in order to maintain resident confidentiality. [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that care was provided to a resident as specified in the plan of care regarding oral hygiene, as evidenced by.

Resident #188 expressed that oral care was not received twice daily, consistently. The plan of care for this resident indicated that the resident was to receive oral care twice daily, including staff to clean mouth and tongue each morning, evening and after meals.

Review of the resident record indicated that the resident did not receive oral care twice daily 11 times, in 21 days.

A Personal Care Provider and the Coordinator of Resident Care confirmed that the expectation was that all residents receive oral care twice daily as specified in their individual care plan. [s. 6. (7)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents at a minimum contained an explanation of the duty under section 24 to make mandatory reports.

A review the Abuse and Neglect of Residents: Zero Tolerance policy, revised date April 2014, revealed that it did not contain an explanation of the duty to make mandatory reports under section 24.

The Vice-President confirmed via email that the Zero Tolerance of Abuse policy does not make reference to the duty to make mandatory reports. [s. 20. (2) (d)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure if the Residents' Council advised the licensee of concerns or recommendations, that within 10 days of receiving the advice, a response was provided to the Residents' Council in writing.

There was no documented evidence to support that a written response was provided to residents within 10 days of concerns or recommendations being identified.
A review of minutes from the Food Committee, which is a sub-committee of Resident's Council, revealed that a written response had not been provided to ongoing concerns noted regarding meal service in January, February, March, and May 2014. The concerns identified included residents feeling hurried to finish meals, residents not getting the assistance they needed and not getting the food they requested, as well as food not being offered one course at a time.

The Coordinator of Nutrition Services confirmed that ongoing meal service concerns were noted in the minutes and that a written response was not provided to residents within 10 days.
The Vice President indicated that she was not aware that a written response was not being provided. [s. 57. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that therapy services for residents of the home were arranged under section 9 of the Act that included,
(a) On-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs, as evidenced by:

Resident #100's last physiotherapy assessment, in August 2013, stated the resident would continue to benefit from range of motion exercises. The resident was found to require physiotherapy services 2 to 3 times per week.

Health record review for Resident #100 revealed the resident did not receive physiotherapy services or another physiotherapy assessment from November 2013 to May 21, 2014.

The physiotherapist revealed that Resident #100 required physiotherapy services and another physiotherapy assessment and acknowledged that the resident did not receive these services from November 2013 to May 21, 2014 and that he/she should have based on his/her assessed care needs. [s. 59. (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3

Findings/Faits saillants :

1. The licensee failed to ensure that all required information was posted in the home, in a conspicuous and easily accessible location, including copies of the inspection reports from the past two years for the long-term care home, as evidenced by:

A review of the Ministry of Health and Long-Term Care Inspection Reports - SM binder, in the library, May 23, 2014, revealed reports in the binder dated from January 2013 to current.
The Coordinator of Resident Care acknowledged that the reports were not posted for the past two years.
The LTCH Licensee Confirmation Checklist signed by the Vice President, Complex, Specialty Aging and Rehabilitative Care on May 13, 2014, confirmed that reports are only posted for one year and the second year is available upon request. [s. 79. (3) (k)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey, as evidenced by:

Interviews with Resident Council Co-Chair and Family Council President confirmed that neither the Residents' Council nor the Family Council were involved in the development and implementation of the satisfaction survey.

The Vice President confirmed that neither Council was consulted in the development and implementation of the satisfaction survey. [s. 85. (3)]

Issued on this 5 day of August 2015 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

London Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DONNA TIERNEY (569) - (A4)

Inspection No. / No de l'inspection : 2014_182128_0009 (A4)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000546-14 (A4)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 05, 2015;(A4)

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

Ontario

Ministry of Health and Long-Term Care

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Order(s) of the Inspector

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

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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) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_217137_0025, 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 prepare, submit and implement a plan for achieving compliance with O. Reg, 79/10, s. 8 (1) (a) & (b), to ensure that polices are implemented in accordance with applicable requirements under the Act and Regulations and that polices and procedures implemented in the home are complied with.

All policies that are not in compliance with the legislation, must be re-written.

Education must be provided to all staff, including registered nursing staff, to ensure that they are aware of the policies.

The submitted plan must identify when and how education will be provided to staff, as well as who will be responsible for providing the education.

The plan must also include how compliance will be monitored on an ongoing basis and who will be responsible for the monitoring.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector - Dietary, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, to Ruth.Hildebrand@ontario.ca by July 16, 2014.

Grounds / Motifs :

1. The home continues to be in on-going non-compliance with the order issued October 18, 2013 related to policies not being complied with regarding skin care, assessment and wound management and pain assessment.

The licensee failed to ensure that the Abuse policy was complied with, as evidenced by:

A review of the policy Abuse and Neglect of Residents - Zero Tolerance - Revised April 2014 indicated the following:
6 When an incident of alleged, witnessed or suspected abuse of a resident occurs, causing harm or the potential for harm to that resident, the person who becomes aware of the abuse must report the incident immediately to the RN who will in turn

notify....
- In the evening, at night or on week-ends, the building Registered Nurse informs the Ministry by calling 1-866-414-0013. Provide the resident's name and specific details about the incident. The RN is to notify the Clinical-on-Call. Include all such incidents on 24-hr. summative report, so the Coordinator can follow up.

The policy was not followed in two instances of alleged abuse:

a. Resident #012 reported to a Registered Practical Nurse that he/she had been a victim of alleged emotional abuse by a Personal Care Provider several weeks before in his/her bedroom.

The Registered Practical Nurse failed to report the alleged abuse to the Registered Nurse as per the home's abuse and neglect policy.
The Coordinator of Resident Care verified the home's abuse policy was not followed. (517)

b. During a resident and family interview, it was revealed that between March - April, 2014, date not confirmed, an incident of alleged, suspected or witnessed abuse was reported to a Registered Nurse.

The Coordinator of Resident Care confirmed the Registered Nurse did not inform the Ministry, did not notify the Clinical-on-Call, the incident was not included on the 24 hour summative report, for follow-up by the Coordinator and the home's policy was not complied with. (137)

2. The licensee failed to ensure that the Resident Weights policy was complied with, as evidenced by:
A review of the policy entitled Resident Weights, revised November 2013, revealed that it was not being followed as the policy indicated that all residents were to be weighed at least monthly.
All residents were to be weighed by the PCP during the first week following their admission to Mount Hope.

A review of the Monthly Weight Report, on May 21, 2014, revealed 80 of 173 residents in the home (46%) were not weighed according to the home's weight policy.
It was noted that 23 residents were not weighed, within the first week of the month as they were not weighed as of May 21, 2014.
All residents were not weighed monthly as noted between November 2013 to current:
34 residents had no weights recorded for one month;
17 residents had no weights recorded for two months;
14 residents had no weights recorded for three months;
3 residents had no weights recorded for four months;
3 residents had no weights recorded for five months.
Additionally, a review of the clinical records for two of three respite admissions (66.6%) revealed that
they had not been weighed upon admission.
The Registered Dietitian acknowledged that weights are not done on a monthly basis for all residents.
The Coordinator of Resident Care and the Vice President stated that the expectation was that the weight policy was followed. (128)

3. The licensee failed to ensure that the policy related to medications was in compliance with and implemented in accordance with applicable requirements under the LTCHA/Regulations, as evidenced by:

A review of the home's policy entitled Medications from Home, revised date of April 2014, revealed that it states "if the physician has authorized the medications, but there is a delay in the drugs being sent to the unit, registered staff may administer the resident's own supply, in order to avoid the resident not getting needed medications. The nurse must document administration of the medications in the eMAR if the medications appear there, or in the Progress Notes using the "eMAR - Medication Administration".

The Regulations indicate no drug is acquired, received, or stored by or in the home or kept by a resident unless the drug has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. This does not apply where exceptional circumstances exist such that a drug prescribed for a resident cannot be provided by, or through an arrangement by, the pharmacy service provider.

A clinical record review for Resident #022, revealed the doctor signed an order for a medication. However, the pharmacy did not supply this medication for the resident.

A Registered Practical Nurse stated that the resident’s personal supply of the medication was opened and had two different medications in the bottle and the RPN was unsure of what either medication was.
The Coordinator of Resident Care acknowledged that the medication from home should not have been used and that the home’s policy was not in compliance with the Regulations. (128)

4. The licensee failed to ensure that the skin and wound care policy instituted was in compliance with and implemented in accordance with applicable requirements under the LTCHA/Regulations, as evidenced by:

A review of the policy, Skin Care and Assessment and Wound Management, revised November 2013, indicated:
Wound Identification and Care, #19 - The nurse refers all identified Stage II, III, IV and X wounds to the dietitian for follow-up, by completing a "Referral to Dietitian" Progress Note in the electronic documentation system. Skin tears are also referred to the dietitian if healing is delayed.

The Regulations require that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian.

Review of the clinical record for Resident # 111 indicates that the resident sustained a skin tear during dressing. The clinical record does not indicate that a dietitian assessment was completed.
A Registered Practical Nurse confirmed that referrals were made only when wounds were assessed as a stage 2 or more severe.

The Coordinator of Resident Care acknowledged that the home's policy on skin and wound management was not in compliance with the Regulations as it did not include that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian. (537)

5. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, as evidenced by:
A review of the home's policy, entitled Skin Care and Assessment and Wound Management,
Revised November 2013, indicated:
Wound Identification and Care, #22 - Wound care is provided by the RN/RPN on the shift the care is assigned to. The nurse providing the care assesses the wound weekly - the assessment finding and current treatment are documented weekly on the "Wound/Skin Assessment" in the electronic documentation system; this assessment includes evaluation of the current plan of care, including dietary measures, etc.; documentation must occur more often than weekly if the wound is rapidly changing.

A review of Weekly Wound/Skin Assessments revealed that the assessments were not consistently being conducted weekly for 3 residents:
a. Resident # 111 - There were 18 days between the initial wound assessment and the next assessment done.

b. Resident # 123 - There were 28 days between the initial wound assessment conducted and the next assessment done.

c. Resident # 142 - Four assessments were not completed weekly and the time frames in-between were 11 days, 14 days and two were 17 days.

Three Registered Practical Nurses confirmed that the expectation was that assessments were completed weekly and that the home's policy was not complied with.
(537)

6. The licensee failed to ensure that the medication policy was complied with, as evidenced by:
Review of the home's policy entitled "Storage of Medications", revised April 2014, revealed medication requiring refrigeration was to be stored in the unit medication refrigerator, physically separate from food products such as applesauce used for medication administration. The policy further indicated other food used for medication administration was never to be stored in the medication fridge.
A medication room refrigerator, contained two unopened yogurts, one open can of ginger ale and one open bottle of Coca Cola.

A Registered Practical Nurse stated the small fridge was used to store medication and that another larger fridge was available to store staff and resident food. The Registered Practical Nurse stated she did not know that food couldn't be stored in the medication fridge.

The Coordinator of Resident Care verified that no food or drinks were to be stored in the medication fridges in the medication rooms and the expectation was that food and drinks belonging to the residents and staff were to be kept in designated fridges outside of the medication rooms. (517)

7. The licensee failed to ensure that the pain assessment and management policy was complied with, as evidenced by:

A review of the policy Pain: Assessment and Management, revised November 2013, indicated the following:
All residents are assessed on admission for the presence of pain.
All residents are assessed, re-assessed quarterly for the presence and quality of pain, as well as whenever there is a change in the health status which has the potential to precipitate pain, using the Pain Assessment tool in the electronic documentation system.
All residents at risk for pain are screened for pain at least once a day.
Pain management interventions are recorded on the Plan of Care and the existence of and management of pain is also recorded in the resident chart.
Tools which may be used to evaluate pain include but are not limited to pain rating scales, including face scales and the Pain Assessment tool in the electronic documentation system.
Residents are also fully re-assessed at each new occurrence of pain (e.g. new site).
Unexpected or intense pain, especially of sudden onset, must be immediately evaluated by the RN.
Nurses evaluate residents after every individual administration of interventions for pain.

A review of progress notes for Resident #016 revealed that there were 18 documented entries in a 14 week period where the resident expressed pain and required an analgesic.

A registered nurse confirmed a pain assessment was not completed and the policy was not complied with. (137)

8. The licensee failed to ensure that the Feeding and Supervision of Residents Who Are Eating policy was complied with, as evidenced by:

A review of the policy Feeding and Supervision of Residents Who Are Eating, revised October 2013, indicated:
#6. For residents who are eating in their room during a meal (due to isolation, etc.):
Supervision must still be provided to ensure the resident is eating safely.
If the resident is accompanied by a responsible adult (e.g. family member), the resident may be supervised by that person; unit staff must ensure this person is educated about the resident's dietary needs and restrictions, as well as any known risks to the resident e.g. known choking risk.
If the resident has no one with them, staff need to provide at least intermittent supervision if the resident is not at choking risk.

Resident # 011 was observed in bed, with a breakfast tray on the bedside table, with the main meal uncovered and all containers opened.

It was confirmed by a Personal Care Provider and a Registered Staff that it was the expectation that all residents were to be monitored if eating in their room and the level of supervision was based on identified needs. It was confirmed that this resident was not a choking risk and required intermittent supervision during eating.

A PCP confirmed that the resident was not checked after the tray was delivered and was not supervised during meal service, as required by the policy.

The Coordinator of Resident Care and the Vice President acknowledged the expectation was that all residents were monitored during eating.
(537)

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

Aug 15, 2014

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

Ministère 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

(A1)

The licensee must ensure that Mount Hope (St. Mary s) and Marian Villa each have an Administrator who works regularly in that position, on site at the home, for at least 35 hours per week.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Grounds / Motifs :

1. The licensee failed to ensure that the home had an Administrator who worked regularly in that position on site at the home, for at least 35 hours per week.

There is one full-time Administrator (Director) for Mount Hope Centre for Long Term Care, which encompasses two long-term care homes; Marian Villa and St. Mary's. St. Mary's has a capacity for 177 residents and Marian Villa has a capacity for 217 residents.
Although there is some administrative support from a St Joseph's Health Care, London Vice-President and a number of other St. Joseph's employees, there is not another 35 hours per week, on site in the home, in the position of Administrator.

Therefore, Mount Hope (St. Mary's) does not have an Administrator (Director) who works regulary on site in the home for at least 35 hours per week.

This was confirmed by the Vice-President of Complex, Specialty Aging and Rehabilitative Care.
(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Jan 01, 2016(A4)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 5 day of August 2015 (A4)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : DONNA TIERNEY - (A4)

Service Area Office /
Bureau régional de services : London