Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2016	2016_254610_0001	035826-15	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

Mount Hope Centre for Long Term Care
21 GROSVENOR STREET P.O. BOX 5777 LONDON ON N6A 1Y6

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

NATALIE MORONEY (610), ALI NASSER (523), INA REYNOLDS (524), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 11, 12, 13, and 14, 2016

The following inspections were conducted concurrently during the RQI Critical Incident #033819-15/CI 537-000007-15 regarding falls.

Follow-up inspection #027711-15/2015_271532_002 regarding personal support services

During the course of the inspection, the inspector(s) spoke with the Administrator, two Care Coordinators, one Director of Environmental Services, one Registered Dietitian, one Director of Housekeeping, one Therapeutic Recreation Specialist, one Nurse Educator, one Registered Nurse, 17 Personal Support Workers, ten Registered Practical Nurses, two Dietary Aides, two Resident Assessment Instrument Nurses, four Housekeepers, 40 Residents, and Families.

During the course of the inspection the inspectors completed interviews, observed resident care, reviewed health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **10 VPC(s)**
- **1 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
O.Reg 79/10 s. 24. (4)	CO #002	2015_271532_0020	524
O.Reg 79/10 s. 73. (1)	CO #001	2015_271532_0020	524

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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. The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observations of Mount Hope on January 5, 6, 7, 8, 12 and 13, 2016, showed areas of disrepair to resident common areas and resident home areas.

On January 12, 2016, during an observation of the St. Mary's building:

A) The fifth floor showed that the ceiling had several large brown marks. The carpet under the brown marks was wet, and there was a bucket that was catching the brown substance.

B) The dining room floor on the first, second and fourth floor, had large black divots and scratches in the floor.

C) The common area on the first, second, and fifth floor, furniture was in disrepair with scratch mark and tears, and the flooring had black marks.

D) Third floor ceiling in the hallway the ceiling had plaster exposed.

Marian Villa Building:

A) The first floor common areas furniture was in disrepair with scratched legs, and a broken air conditioner mounted on the wall.

B) One door and wall had paint chipped, and scratched door.

C) The hallways on the fourth floor had paint chipped along the hall corridor.

D) Fourth floor dining area had paint scratched on the walls, and plaster chipped.

E) Common area on the fourth floor had furniture in disrepair, top surface on the table was peeling off, and space heater had paint scratches.

F) Four out of five doors on the fourth floor "Y" hallway doors were damaged and scratched.

G) Two Hand pump stations had been removed off the walls and exposed the broken system still on the wall on the fourth floor.

The Administrator # 103 and Care Coordinator # 104 on January 13, 2016, observed the home areas that had furniture disrepair and confirmed the home area disrepair.

A review of the preventive maintenance plan on January 13, 2016, showed that there was no scheduled, routine, preventive, or remedial maintenance plan for resident common areas or home areas for the Mount Hope building.

The Director of Facilities Management #144 confirmed that there was no schedule for remedial maintenance such as painting rooms, hallways, and common areas,and relied on work orders from the home and confirmed that they do not audit or evaluate the home remedial maintenance plan.

The Administrator confirmed that it was the homes expectation that the home furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 90. (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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out the planned care for the resident.

Point Click Care (PCC) documentation for resident # 002 showed that the resident had moderate pain, daily.

The pain assessment completed in PCC showed that the resident had moderate to severe pain.

A review of the resident's plan of care showed that resident # 002 did not have a plan of care completed for focus of pain with interventions and goals.

Pain assessment and management policy included:

"Pain management interventions are recorded on the plan of care for the resident.

When any member of the health care team perform an assessment or are working with the resident in any capacity where they identify the existence of pain, this is communicated to the registered staff caring for the resident, so that this can be included in the overall pain assessment and strategies built into the care plan".

On January 11, 2016, the Resident Assessment Instrument (RAI) Nurse # 109 confirmed the resident should have had a plan of care for pain, with interventions and goals to monitor pain. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

a) A room observation for resident #022 on January 6, 2016, at 1020 hours revealed one bed rail in use but was not part of the plan of care.

b)Resident #022 on January 6, 2016, revealed the resident had a treatment order.

Record review for resident #022 revealed there were no interventions documented for the treatment.

The Coordinator of Resident Care #115 confirmed this intervention was not documented to set out clear direction to staff. [s. 6. (1) (c)]

3. A resident was not able to access an activity related to decline in activities of daily living.

The Administrator # 103 confirmed that it would be the home's expectation that the care set out in the plan of care would be based on the needs and preferences of that resident related to the activity and needs.

4. The licensee has failed to ensure that the plan of care for Personal Assistive Device (PASD) was based on an assessment of the resident and the resident's needs and preferences

During stage one of the RQI process resident # 001 was observed sitting in a mobility device with a front fastening seat belt.

Observation of the resident on January 8 and 11 2016, showed that the resident was wearing the front fastening seat belt.

An interview with the nurse # 114 on January 8, 2016, indicated that the seat belt was used to assist the resident with positioning.

A clinical record review revealed the plan of care did not include information about the seat belt and when it should be used.The Care Coordinator # 104 and the Administrator # 103 confirmed on January 8, 2016 that the seat belt was not part of the plan of care and it should have been. [s. 6. (2)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A clinical record review of resident's # 062's plan of care included interventions to assist resident's behaviour.

A review of the plan of care showed that staff were not providing care as specified.

This was confirmed with the Administrator who also confirmed that it would be the home's expectation that the care set out in the plan of care would be provided to the resident as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Record review of the current care plan for resident #024 under the nutrition focus identified a goal to maintain the resident's weight goal range.

The resident had a significant weight loss and the goal was not reveiwed and revised.

This was confirmed by the Registered Dietitian #140 on January 12, 2016. The

Registered Dietitian further confirmed the expectation that the care plan goal be reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 ensure that the plan of care set out planed care, clear directions,is based on an assessment of the resident and care set out in the plan of care is provided to the resident and the resident is reassessed reviewed and revised when care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that policy - Restraints, Physical, Chemical & Environmental put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A review of policy - Restraints, Physical, Chemical & Environmental point 28. stated "all residents who are restrained physically must be released from the restraint and repositioned every 2-3 hours at a minimum."

An interview with the Administrator # 003 confirmed the policy stated all residents who are restrained physically must be released from the restraint and repositioned every 2-3

hours at a minimum and the regulations 110 (2) (4) state "that the resident is released from the physical device and repositioned at least once every two hours."

Therefore, the home's policy is not in compliance with requirements under the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A record review revealed the Personal Support Worker (PSW) #125 had documented that oral care had been completed for resident #001.

An interview with PSW #125 revealed the PSW was not the person who had completed the oral care task.

The documentation Nursing Charting in the Progress Notes of the Electronic Documentation System Policy included:

"The RN/RPN who deliver care performs an assessment or has information about a resident is the person who documents the care or information".

An interview with the Care Coordinator #104 confirmed it was the homes expectation that the documentation should have been completed by the care giver who provided the care to the resident and that the protocol instituted was not complied with on January 11, 2016. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

b) Review of the home's Resident Weights policy dated November 2013, stated that "Weights will be recorded by the PCP in the point of care section of the electronic documentation system. Any resident experiencing a significant weight change (one-month change of approximately 1.5 kg for residents below 40 kg, and approximately 2.0 kg for residents above 40 kg) must be re-weighed. Ideally re-weighs should be done automatically by the PCP when they notice the significant change at the time of the original weight."

i) Review of the electronic weight records on Point Click Care for resident #001 revealed

the resident experienced a significant unplanned weight loss over one month.

ii) Review of the weight records for resident #003 revealed the resident experienced a significant unplanned weight loss over one month.

There was no documented evidence that the residents were re-weighed in the point of care section of the electronic records after the original weights were taken.

The Registered Dietitian #118 on January 8, 2016, confirmed there was no documented re-weigh of the residents. The Registered Dietitian #118 also confirmed the home's expectation was that any resident experiencing a significant weight change over one month must be re-weighed and indicated that the Resident Weights policy was to be complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

Observations during the initial tour revealed that:

i) W513 tub room door was open and unattended.

PSW # 126, confirmed that the home's expectations were to keep tub room door closed and locked when not in use.

ii) Second floor laundry room door was open and unattended.

Nurse # 127, confirmed that the expectation was to have the door closed and locked when not attended and in use.

The doors to room W023 Volunteer room was open and unattended and unlocked.

This was confirmed by Administrator # 103, who also confirmed the home's expectation would be that all doors leading to non-residential areas were locked when they were not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas were locked when they were not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations during the Resident Quality Inspection (RQI) on January 5, 2016, revealed that the front lounge had no resident-staff communication system.

Interview with the Administrator # 103 confirmed that it was the home's expectation to have a resident-staff communication and response systems that would be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: 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).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes, 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.

A review of an assessment completed in PCC showed the resident# 003 had demonstrated moods and behavioural concerns.

The Policy for Resident Aggressive and Responsive Behaviours included;

"Examples of responsive behaviours include but are not limited to..... wandering, hoarding, rummaging.

For resident's who demonstrate behaviors staff will identify in their residents where possible, the triggers or antecedents for responsive behaviours, in order to prevent the behaviour from re occurring, and to reduce its frequency".

A review documentation revealed that BehaviouralSupport Team was not involved and there was no consultation completed.

There was no interdisciplinary assessment of the resident mood and behaviour patterns.

The RAI Nurse # 109 confirmed that there should have been a plan of care for the residents mood and behaviours, as well as assessments by BSO with interventions for monitoring of triggers.

The Care Coordinator # 104 also confirmed that the resident should have had a plan of care for the responsive behaviours. [s. 26. (3) 5.]

2. The licensee has failed to ensure that the plan of care related to pain was based on an interdisciplinary assessment with respect to the resident's health conditions.

A review of Point Click Care documentation showed that resident # 003 had a medical condition.

On January 8, 2016, a record review of the resident's plan of care showed that resident # 003 did not have a plan of care completed for health conditions.

The policy included:

"Interventions are recorded on the plan of care for the resident.

When any member of the health care team perform an assessment or are working with the resident in any capacity where they identify the existence of pain, this is communicated to the registered staff caring for the resident, so that this can be included in the overall assessment and strategies built into the care plan".

On January 11, 2016, the Resident Assessment Instrument (RAI) Nurse revealed that the health condition related to the decline should be part of the plan of care with interventions and goals to monitor. [s. 26. (3) 10.]

3. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's activity patterns and pursuits and spiritual and religious preferences.

Record review included an assessment of #021's activity preferences and received spiritual care programming.

The Therapeutic Recreation Specialist #146 confirmed the resident's plan of care related to activity patterns last revised July 20, 2015, did not include the resident's activity, spiritual and religious preferences based on the assessment. [s. 26. (3) 22.]

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 responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes, 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces were implemented.

Observations by inspector # 521 on January 6, 2016, revealed that a privacy curtain was soiled with crusty dried green debris. This was confirmed by PSW # 110.

A tour of the resident’s rooms and common areas was completed with the Administrator to confirm observations, one room had a privacy curtain with a large stain about 50cm of dried brown fluids. One room had the bottom part of the privacy curtain stored in the rubbish bin in between the two bed side tables.

The fifth floor sunroom and dining room had darkened floors and stained baseboards, baseboards in hallway and by elevators had accumulation of thickened grey substance.

The homes Procedure Cleaning Standards and Frequencies St.Joseph's Health Care London included:

"Therefore, cleaning is done at least daily and more frequently if the risk of environmental contamination is higher (i.e. intensive care units). These areas include but are not limited to: bed rails, bed controls, carts, bedside tables, light switches, handles, door knobs, push plates, call bells/lights, bed controls, phones, IV pumps, blood pressure cuffs, monitoring equipment, computer keyboards, door handles, chair arm, towel bars, grab bars, ledges, sills, edges of privacy curtains, pull cords in washrooms, toilet seats, lids and flush handle, audio-visual equipment and remotes.

Environmental Cleaning and Standards and Frequencies: Base boards are to be cleaned weekly by housekeeping".

A tour of resident's rooms and common areas with Director of Housekeeping # 147 and the Administrator # 103 confirmed the observations and confirmed the daily and weekly cleaning had not been fully completed.

The Administrator # 103 confirmed that it was the home’s expectation that the home and furnishings would be kept clean and the home's housekeeping policies and procedures were to be fully implemented. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces were implemented, 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 has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

Observations during the initial tour revealed that:

a) W513 tub room door was open and a bottle of disinfectant cleaner was accessible.

This was confirmed by PSW # 126. The PSW also confirmed that the home's expectations were to keep hazardous substances inaccessible to residents at all times.

Administrator # 103 confirmed the home's expectation would be that the hazardous substances were kept inaccessible to residents at all times. [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 were 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation for the use of the physical device to restrain a resident included the person who applied the device and the time of application.

A record review showed that a resident had a restraint but was not signed by the staff who applied the restraint.

An interview on January 12, 2016, at 1200 hours with Care Coordinator #104 confirmed the documentation of the applied restraint for resident #001 did not include the person who applied the device and the time of the application. [s. 110. (7) 5.]

2. The licensee has failed to ensure that the documentation included every release of the device and repositioning.

A record review revealed resident #001 used a physical device as a restraint. There was no documentation of the release of devices and all repositioning.

An interview with Care Coordinator #104 confirmed the documentation did not include the release of the restraint device and repositioning for resident #001 on the specified dates and it was the home's expectation that the documentation included every release of the device and repositioning for residents who have restraints applied. [s. 110. (7) 7.]

3. The licensee has failed to ensure that the documentation included the removal of the device, including time of removal or discontinuance and the post-restraining care.

An interview with Care Coordinator #104 confirmed the documentation for resident #001's removal of restraint including the time of removal was not completed and it was the homes expectation that the documentation include the removal of the device, including time of removal. [s. 110. (7) 8.]

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 documentation include the person who applied the device and the time of application, release of the device and repositioning, and the removal of the device, 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 has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies,and that was secured and locked.

Observations on January 08, 2016, showed that there was a medication in a resident area.

The home confirmed that drugs should be stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies,and that was secured and locked.

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 that drugs are stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies, that was secured and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug destruction and disposal policy provided for the following; that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

Observations on January 11, 2016, revealed there were controlled substances to be destroyed left in the medication cart.

The Destruction and storage of surplus, expired or discontinued medications policy included:

"Narcotics and controlled drugs for destruction must be kept in the locked narcotic bin in the locked medication cart until the pharmacist visits the unit; NCDs for drug destruction must be clearly separated from NCDs for regular administration by placing the NCDs for destruction in a clear zip locked bag".

An interview with the Care Coordinator #004 on January 11, 2016, confirmed this was the current practice and that the practice did not comply with the legislation and that the home had failed to ensure that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred. [s. 136. (2) 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 the drug destruction and disposal policy provided for the following; that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director in writing within 10 days of becoming aware of an incident with the following information of the incident:

Analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A clinical record review and a review of Critical Incident (CI) # C596-000022-15 should have been amended or updated.

An interview with Care Coordinator # 115 confirmed that the home did not respond and amend the CI. Care Coordinator # 115 confirmed that it was the home's expectation that the CI should have been updated. [s. 107. (4) 4.]

Issued on this 10th day of February, 2016

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

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MORONEY (610), ALI NASSER (523), INA REYNOLDS (524), REBECCA DEWITTE (521)
Inspection No. / No de l'inspection :	2016_254610_0001
Log No. / Registre no:	035826-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 28, 2016
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 :	Mount Hope Centre for Long Term Care 21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Groen

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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must prepare, submit, and implement a plan, to demonstrate how they will schedule and put into place routine, preventive and remedial maintenance in the home that will address the issues as noted in the grounds.

a) Please indicate what procedures will be developed to ensure the home is maintained and indicate who will be responsible for developing the schedules and procedures for routine, preventive and remedial maintenance, as well as who will be responsible for ensuring the schedules and procedures are utilized on an ongoing basis.

b) This plan must also identify time frames when each of the components will be achieved.

c) Please submit the written plan to Natalie Moroney, Long Term Care Homes Inspector Nursing, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor London, On, N6A 5R2, via email to natalie.moroney@ontario.ca by March 4, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observations of Mount Hope on January 5, 6, 7, 8, 12 and 13, 2016, showed areas of disrepair to resident common areas and resident home areas.

On January 12, 2016, during an observation of the St. Mary's building:

A) The fifth floor showed that the ceiling had several large brown marks. The carpet under the brown marks was wet, and there was a bucket that was catching the brown substance.

B) The dining room floor on the first, second and fourth floor, had large black divots and scratches in the floor.

C) The common area on the first, second, and fifth floor, furniture was in disrepair with scratch mark and tears, and the flooring had black marks.

D) Third floor ceiling in the hallway the ceiling had plaster exposed.

Marian Villa Building:

A) The first floor common areas furniture was in disrepair with scratched legs, and a broken air conditioner mounted on the wall.

B) One door and wall had paint chipped, and scratched door.

C) The hallways on the fourth floor had paint chipped along the hall corridor.

D) Fourth floor dining area had paint scratched on the walls, and plaster chipped.

E) Common area on the fourth floor had furniture in disrepair, top surface on the table was peeling off, and space heater had paint scratches.

F) Four out of five doors on the fourth floor "Y" hallway doors were damaged and scratched.

G) Two Hand pump stations had been removed off the walls and exposed the broken system still on the wall on the fourth floor.

The Administrator # 103 and Care Coordinator # 104 on January 13, 2016,

observed the home areas that had furniture disrepair and confirmed the home area disrepair.

A review of the preventive maintenance plan on January 13, 2016, showed that there was no scheduled, routine, preventive, or remedial maintenance plan for resident common areas or home areas for the Mount Hope building.

The Director of Facilities Management #144 confirmed that there was no schedule for remedial maintenance such as painting rooms, hallways, and common areas,and relied on work orders from the home and confirmed that they do not audit or evaluate the home remedial maintenance plan.

The Administrator confirmed that it was the homes expectation that the home furnishings and equipment are maintained in a safe condition and in a good state of repair. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 22, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

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