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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 3, 2016	2016_188168_0017	019294-16, 024289-16	Complaint

Licensee/Titulaire de permis

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

Long-Term Care Home/Foyer de soins de longue durée

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

LISA VINK (168), LESLEY EDWARDS (506)

The purpose of this inspection was to conduct a Complaint inspection regarding complaints brought forward to the home between 2012 and 2013.

This inspection was conducted on the following date(s): August 12, 16, and 17, 2016.

During the course of this inspection the following inspections were conducted concurrently:
Complaint Inspections
019294-16 - related to prevention of abuse and neglect
024289-16 - related to dealing with complaints.

During the course of the inspection, the inspector(s) spoke with the Director, the Nursing Coordinators, registered nursing staff, human resource personnel, personal support workers, former staff of the home, family members, private duty caregivers and residents.

During the course of this inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant documents including policies and procedures and meeting minutes, complaint logs, investigative notes and clinical records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

Progress notes of an identified date and a Complaints Form created the following date, identified that resident #105 and their family voiced concerns regarding the resident's safety due to the actions of their roommate.
When the concern was first identified registered staff #209 and #214 requested that the night shift increase monitoring of the resident. The following month the concern was reported to staff #209 again at which time it was referred to nursing management staff #213.
Two days later, staff #213 sent an email to the resident's unit which identified interventions to be put into place, including but not limited to: every 30 minute checks of the resident, a bed sensor and reassurance, until a planned long term solution was able to be completed.
A review of the plan of care, for resident #105, which included all revisions, was reviewed during this inspection.
This plan did not include the care needs required for the resident related to the frequency of monitoring and the bed sensor after they were identified.
Interview with staff #209 confirmed that she would not have included the need for increased monitoring into the plan of care when suggested and a review of the plan by staff #213 confirmed that these changes in care needs were not part of the plan of care.
The plan of care was not revised when there were changes in the resident's care needs.
[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 to 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, the resident's care needs change, to be implemented voluntarily.

WN #2: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;

O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
The complaint was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint. For those complaints that could be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint was provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph 3 was provided as soon as possible in the circumstances. A response was made to the person who made the complaint, which indicated, what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The licensee has failed to ensure that a documented record was kept in the home that included, 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 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 licensee has failed to ensure that, the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response.

A. Resident #101 and their family verbalized concerns regarding the care provided by staff on an identified day, as recorded in the progress notes. According to the clinical record the family was directed, by nursing staff, to speak with management staff #215. A progress note dated approximately one week later, by registered staff #207, indicated

that during the previous night the resident's family voiced concerns regarding two nursing staff, including staff #212, and that the family indicated that they had shared their concerns with management staff #215.
Staff #207 responded to the statements made by the family by sending an email to staff #215 regarding the concerns expressed related to the identified staff.
Staff #215 recorded, in a return email to staff #207 and the Director of the home, that she was unaware of the specific concerns related to the staff and requested that the family put their concerns in writing and contact her directly with additional information.
Following the initial email staff #215 notified management staff #216 that she had spoken with staff #212, who agreed to refrain from providing care to resident #101 and that the issue had been "taken care of".

Progress notes during the following month, identified that family reported that they observed staff, who they were told by staff #216 would no longer care for resident #101, and believed to be staff #212, provide care to the resident, which was later confirmed by staff #207.

According to the family they communicated their request regarding staff #212 not to provide care to the resident during two of the Care Conferences. The family indicated that they had provided a desired written care routine for the resident and a written letter of complaint, regarding a number of issues, including that staff #212 was not to provide care to the resident at one of the conferences. A second letter of complaint was provided at the second conference, which again identified that staff #212 was not to provide care to the resident as indicated by the family. These documents were given to the members of the care team who participated in the conference according to the family and were provided to the Inspector by the family as part of this inspection.

The following year, a Complaint Form was initiated by management staff #213, due to the family concern that staff #212 provided a shower to the resident the day before. This concern was investigated and it was identified that the staff did not provide care to the resident as suspected.

A review of the documents available in the home and provided for review did not include all of the required information.
When the concern was first identified there was no documentation available to support: the date that staff #215 became aware of the specific concerns, of an investigation which included interviews of the resident and family, the date a response was made to the complainant and a description of the response, or the response made by the

complainant, which was confirmed by management staff #204. Interview with staff #215 during this inspection, identified that she had no recall of the specific situation but in her opinion would have completed an investigation into the concerns and followed up with the actions taken with the family.

When care was provided to the resident, which was believed to be completed by staff #212, there was no documentation available to support actions taken by staff in the clinical record or a Complaint Form, as confirmed by management staff #204. Interview with registered staff #207, following a review of the specific progress note suggested that she could not recall the specific situation; however, was aware that one staff member was not to provide care to the resident. Interview with staff #212 confirmed her knowledge that she was not to provide care to the resident and she identified that she did not provide care to the resident again after she agreed not to be involved in the resident's care. Interview with management staff #215 identified that to her recall staff #212 did not provide care to the resident again after the issue was resolved.

When the issue was raised, by the family, at the Care Conferences, records reviewed did not include documentation of action taken in the notes recorded at the time of the conference, nor were any Complaint Forms created. The second Care Conference record did include a notation under "family concerns" that there was a typed note in the front of the resident's chart, which was provided by the family, on a specified date, regarding to the resident's care and routine, which should be discussed and changes made as needed. A review of the clinical record by the Inspector did not locate the written letters as provided by the family. Registered staff #203, who chaired the initial conference, had no recall of the written letter after a review of the notes she recorded of the conference. Registered staff #211, who chaired the second conference, had no recall of the written letter after a review of the notes she recorded of the conference. Interviews with management staff #200, #204 and #213 each indicated that they were not familiar with the identified letters of complaint when they were provided for review by the Inspector.

When the concern was brought forward and recorded on the Complaint Form it was documented that the issue was investigated and was unfounded; however, there was no record of the date a response was provided to the complainant, a description of the response, nor the response made by the complainant, which was verified with staff #213.

B. A progress note for resident #101 identified that the family questioned the lack of soiled clothing over a one week period of time, as recorded by registered nursing staff

#217.
There was no indication in the progress notes reviewed, from the time that the concern was identified into the following month, that the concern was investigated, or efforts made to resolve the concern, follow up activities with the complainant nor a final resolution.
Interview with staff #217 included a review of the progress note, at which time it was verified that she did not have a recall of the situation; however, that she would not have completed an investigation outside of speaking to the staff on the identified shift and that no additional records were completed nor follow up response with the family.
The progress note was reviewed, by management staff #200 and #204, both who verified that the issue would be considered a complaint and action should have been taken as detailed in the Complaints Management process; however, they were unfamiliar with the concern until the time of this inspection.
Staff #204 verified that there was no Complaint Form created for this concern, as required, that it was not included in the Complaints Log and for this reason would not have been included in the quarterly review and analysis of complaint trends.

C. Resident #105 and their family voiced concerns to staff at the home intermittently over a three month period regarding the resident's safety due to the actions of their roommate.
A review of emails, progress notes and a Complaints Form verified that the home investigated the concerns identified and initiated interim interventions, until a planned long term solution was completed.
A review of the available documentation related to the concerns and interview with management staff #213 verified that the records available in the home did not consistently include the final resolution the the issue as well as the date that every response was made to the complainant, a description of the responses provided, as well as the response of the complainant.

D. Caregiver #210 reported to the Inspector that previously they verbally expressed concerns to management staff #213 and #215 about a shower provided to an identified resident by nursing staff #219. The caregiver identified that the management staff failed to address the concern regarding staff #219. A review of the documents available and provided to the Inspector confirmed that the complainant's concerns were reported and documented by management staff #213. Interview with staff #213 confirmed that they recorded the identified concerns; however, that they did not complete a Complaints Form or any investigation into the concerns but rather passed their notes to management staff
#215 to address. Management staff #215 was able to recall a portion of the caregivers

concerns after reviewing their written notes and indicated that a Complaints Form should have been completed for these concerns; however, could not recall if this was completed and was unable to verify if they followed the legislative requirements for the management of complaints. A review of all of the Complaints Forms completed did not include a form for the issue of bathing identified by the caregiver as confirmed by management staff
#204.

Recently management staff #204 had a meeting with caregiver #210. During this meeting, caregiver #210 expressed that their previous concerns regarding a shower was not addressed and identified a second resident, by first name only, also expressed concerns related to their shower provided by staff #219. Management #204 confirmed that as of the time of this inspection they had interviewed some staff regarding the allegation; however, not yet completed a full investigation into the concerns. A review of the Complaints Forms did not include this concern. The licensee did not ensure that a documented record was kept in the home for all complaints nor that an investigation into the complaint was completed within 10 days.

E. Family of resident #106 identified concerns over the course of a month related to missing resident items, according to the progress notes. When the concern was first identified it was recorded in the clinical record, communicated to security and management staff #213, who initiated a Complaints Form related to the issue.
Later concerns were again brought forward by the family related to missing items. At this time the family was encouraged to speak with management staff #213, according to the progress notes. Staff #213 responded to this concern by amending the Complaints Form and sending an email to the resident's unit, which identified that she would address the missing money; however, requested that staff follow up on the other missing items and keep an eye on the resident's room. Registered staff #209 responded to this email from staff #213 and indicated that she had not seen one of the items for years, was not aware of another missing item and suggested that family go to the laundry or provide a more detailed description of the items to know if they were in an other resident's room.
Management staff #213 held a meeting with the family to further discuss the concerns.
A review of the Complaints Form and interview with staff #213 indicated that follow up actions were completed and that the issue was resolved.
Interview with registered staff #209 verified that she did not take additional actions related to the email she received as she did not feel that the items were missing or a current issue.
Interview with management staff #213 indicated that she had frequent contact with the family and put interventions in place to address the concerns; however, verified that not

all discussions with the family nor the response of the family was consistently documented as required.

F. Interviews with management staff #213, #215 and #216 each verified that for a period of almost two years (2012 to 2013) the home did not consistently record complaints nor was there a process in place to review complaints and analyze trends at least quarterly, which was confirmed by email correspondence from staff #215 to staff #213 and #216.
Interviews with management staff #213, #215 and #216 each verified that the home had previously began to review complaints and analyze trends on a "routine" basis although a frequency could not be verified.
Staff #215 and #216 identified that staff #216 took minutes of these meetings; however, no records of quarterly reviews of complaints could be located in the home prior an identified date as verified by management staff #204. [s. 101.]

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 compliance with O. Reg 79/10 s. 101(1)(2)(3), to be implemented voluntarily.

Issued on this 6th day of October, 2016

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

Original report signed by the inspector.