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
Sep 29, Oct 20, 2016	2016_217137_0014	009790-14, 001938-16, 005693-16, 006355-16, 010088-16, 010999-16, 015709-16, 015871-16, 017034-16, 017180-16	Critical Incident System

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

MARIAN MACDONALD (137), ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 7-10, 14-17 and 21-22, 2016

The following concurrent inspections were conducted during this Critical Incident System inspection: Critical Incident Log # 005693-16 (CI # C596-0000011-16) related

**to alleged resident to resident sexual abuse;
Critical Incident Log # 001938-16 (CI # C596-000001-16 & CI #C596-000003-16) related to alleged resident to resident sexual abuse;
Critical Incident Log # 006355-16 (CI # C596-000008-16) related to alleged resident to resident physical aggression;
Critical Incident Log # 010088-16 (CI # C596-000022-16) related to alleged staff to resident physical abuse;
Critical Incident Log # 010999-16 (CI # C596-000023-16) related to alleged family to resident physical abuse;
Critical Incident Log # 015709-16 (CI # C596-000031-16) related to alleged resident to resident physical abuse;
Critical Incident Log # 015871-16 (CI # C596-000032-16) related to alleged neglect of a resident;
Critical Incident Log # 017034-16 (CI # C596-000035-16) related to fall prevention;
Critical Incident Log # 017086-16 (CI # C537-000035-15) related to alleged resident to resident physical abuse;
Critical Incident Log # 017180-16 (CI # C537-000005-15) related to alleged resident to resident physical abuse;
Critical Incident Log # 009790-14 (CI # C537-000042-14) related to alleged financial abuse;
Complaint Log # 018132-16 (IL-45132-LO) related to multiple care concerns and alleged resident abuse;
Complaint Log # 002445-16 (IL-42243-LO) related to multiple care concerns and alleged neglect of the resident;
Complaint Log # 004206-16 (IL 42773-LO) related to multiple care concerns;
Complaint Log # 005417-16 (IL-43155-LO; LI-43224-LO; IL-43250-LO; IL-43357-LO; IL-43346-LO & CI # C596-000012-16) related to multiple care concerns, alleged neglect of the resident and restraints.**

During the course of the inspection, the inspector(s) spoke with Director, Vice-President, Privacy Officer, Two Coordinators - Resident Care, Administrative Assistant, Coordinator Facilities, Two Registered Practical Nurses (RPN) - Long Term Care (LTC) Support Specialists, Chaplain, Hairdresser, Five Registered Nurses , 13 Registered Practical Nurses, 25 Personal Care Providers, 19 Residents and family members.

Inspectors also conducted tours of the home, observed resident-staff interactions, care provision, reviewed internal and external investigative reports, residents'

clinical records, relevant policies and procedures and staff education records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **8 VPC(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that residents were protected from neglect by the licensee or staff in the home.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg.79/10, s.5

A review of a Critical Incident System (CIS) revealed that an identified resident was left unattended, secured to a device, for an identified period of time, resulting in altered skin integrity.

The Coordinator - Resident Care # 105 said in an interview, with Inspector # 523, that through interviews and an internal investigation, it was determined that PCP # 113 was made aware that resident was left unattended, did not complete hourly checks on resident and did not know if the resident was in their room or on the unit.
The Coordinator - Resident Care # 105 said the identified resident was neglected as they were left unattended and secured to a device for an identified period of time.
The Coordinator - Resident Care # 105 confirmed that the identified resident was not protected from neglect by identified staff members on that shift.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 3, actual harm. [s. 19. (1)]

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. 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 that the home was equipped with a resident-staff communication and response system that cannot be cancelled at the nurse's desk or at any other location other than the point of activation.

On June 15, 2016 at approximately 1300 hours, Inspector # 523 observed a Personal Care Provider (PCP) deactivating the resident-staff communication and response system, on Marian Villa 2 (second floor), by lifting and replacing the telephone handset on the call bell intercom, which was located at the nurses' desk. Registered Practical Nurse # 108 stated the nurse call system could be cancelled at the nurses' desk.

On June 15, 2016 Inspector # 137 and Inspector # 523 observed the resident-staff communication and response system, on Marian Villa 2 (second floor) at 1338 hours and Marian Villa 4 (fourth floor) at 1347 hours, allowed calls to be cancelled at the point of activation, as well as by pressing the talk and listen button or "C" button on the call bell intercom and by lifting and replacing the telephone handset on the call bell intercom, which was located at the nurses' desk.

Personal Care Provider (PCP) # 125 and Registered Practical Nurses # 108 and # 132 said the nurse call system could be cancelled at any of the four identified locations.

During a tour of the home, on June 15, 2016 at 1530 hours, the Director # 100 said the nurse calls, on Marian Villa, could be cancelled at any of the four identified locations and nurse calls should be cancelled only at the point of activation.

The scope of this area of non-compliance is a pattern, there is previous related non-compliance and the severity is determined to be a level 2, potential for actual harm. [s. 17. (1) (c)]

Additional Required Actions:

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

WN #3: 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.

Observations on June 16, 2016 at 1210 hours on Marian Villa (MV) third floor revealed that the door of Bathing Suite room # Z315 was left unlocked, open and unattended.
A bottle of Disinfectant Cleaner, a bottle of Tub, Basin and Tile cleaning solution were accessible to residents, as the Bathing Suite was located in the resident care area, in close proximity to resident rooms and the Bathing Suite door was in the hallway.
Inspector # 523 spent five minutes in the tub room and no staff member was in attendance or in visible vicinity.
Inspector approached RPN # 144 who confirmed the observation and said the expectation was to have the door to the tub room locked when unattended and all chemicals would be kept inaccessible to residents at all times. [s. 91.]

2.On June 15, 2016 at 1201 hours, the Trends Hair Salon door was observed open, the room was unattended and the lights were turned off. The Salon was located between the Wellness Centre, Café and in close proximity to the elevators, which are readily accessible to residents, visitors and staff. There were no residents in the Salon but residents were observed going to the other identified areas.
Hazardous substances were observed accessible to residents. Accessible, on the counter, were one container of comet cleanser, one container of sparkle and shine with ammonia, four bottles of Selsun medicated shampoo and one bottle of Denorex medicated shampoo.
Inspector # 137 observed an unlocked cabinet which contained Barbicide, Developer (Peroxide), room refresher, bathroom cleaner, several hair dyes and perm solution, one gallon bottle each of hair spray and disinfectant cleaner, one - one Litre container of rescue disinfectant and bleach powder.

A hairdresser # 154 said the room was only unattended at lunch time and was not aware the door had to be locked at all times when unattended.

The Director # 100 observed the Salon door open, unattended and that hazardous substances were accessible to residents. The Director # 100 also said that the door was to be locked at all times when unattended, to mitigate potential risk to residents.

The scope of this area of non-compliance is widespread, there is previous related non-compliance and the severity is determined to be a level 2. [s. 91.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the plan of care, for an identified resident, indicated the resident exhibited a specific behaviour and included a specific intervention to direct staff when this behaviour was exhibited.

A clinical record review indicated that when Personal Care Providers (PCP) # 143 and # 153 attempted to provide care to the identified resident at a particular time, the resident exhibited responsive behaviours and became upset.
PCP # 153 did not follow the intervention identified in the plan of care, if the resident exhibited a specific behaviour.

Coordinator - Resident Care # 105 said PCP # 153 did not follow the care plan when the resident exhibited the specific behaviour.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan and
that the the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #5: 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 was in compliance with applicable requirements under the Act.

O. Reg. 79/10, s.53(1)3 requires the licensee to ensure resident monitoring and internal reporting protocols are developed to meet the needs of the residents with responsive behaviours.

A review, with Coordinator - Resident Care #105, of the home's Resident Aggression and Responsive Behaviours policy, revised date April 2016, directed staff in policy #6 that: "all incidents involving responsive behaviours are documented in the resident chart as well as in the online Patient Safety Reporting System (PSRS), regardless of whether or not injuries occurred to any involved persons. If other people (e.g. other residents, visitors) were involved in any incident of aggression, these people should be included in the PSRS report".

A clinical record review revealed that resident # 020 had 24 documented entries in the progress notes as behaviours.

A review of the clinical record Point Click Care (PCC) with Coordinator - Resident Care # 105 confirmed that none of the 24 behaviour progress notes were documented in the Patient Safety Reporting System (PSRS).
Coordinator - Resident Care # 105 confirmed that the home's policy was not complied with.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 1, minimal harm. [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 is in compliance with applicable requirements under the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled Abuse and Neglect of Residents: Zero Tolerance, revised date December 2015, directed staff under section 6 that "when any incident of alleged, witnessed or suspected abuse of all types or neglect of a resident occurred it was mandatory that the person who became aware of the abuse, reported the incident immediately to the RN".

In an interview, RPN # 108 said a PCP had informed them that an identified resident was left unattended and secured to a device.

RPN # 108 observed the resident and reported that the resident did not appear to be in distress.

RPN # 108 confirmed that they considered this incident as neglect. The RPN # 108 understood that this was neglect and understood their role was to assess the resident and report the incident to the RN.

A review of the internal investigation report revealed that RPN # 108 was made aware that the resident was left unattended and that they did not report that to the Registered Nurse (RN) or the RPN working on the following shift.

Coordinator - Resident Care # 105 confirmed in an interview that RPN # 108 was made aware of the incident of neglect on that day and that they did not report that incident to anybody. The expectation was that they would call the RN and the investigation would start immediately.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 20. (1)]

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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents was complied with.

A review of the home's policy named Restraints: Physical, Chemical & Environmental dated September 2013, directed staff under procedure #28 that all resident who are restrained physically must be released from the restraint and repositioned every 2-3 hours at a minimum. This was also documented by the PCP in the electronic documentation system.

Coordinator - Resident Care #105 confirmed in an interview that the policy directed staff to release and reposition residents every 2-3 hours. A review of O.Reg. 79/10,s.110 (2) (4) with Coordinator - Resident Care #105, revealed that residents were to be released from the physical device and repositioned at least once every two hours.

Coordinator #101 said in an interview that this noncompliance was issued previously but they did not have time to make the changes.

The scope of this area of non-compliance is widespread, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 29. (1)]

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 written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that alternatives to restraining the resident had been considered and tried where appropriate.

A clinical record review for resident # 020 revealed that the resident was on physical and chemical restraints and the physical restraint had been applied on a daily basis.

A review of the Medication Administration Record, over a three month period, revealed that the identified resident was administered chemical restraining medications, as needed (PRN), on 20 occasions.

An interview with Behaviour Supports Ontario (BSO)/PSW # 121 revealed that BSO had not assessed the resident for responsive behaviours, during the identified period of time.

The Coordinator - Resident Care # 105 said in an interview that the resident was known to have responsive behaviours since admission.
A clinical record review with Coordinator - Resident Care # 105 confirmed that the resident was restrained by a physical device and chemical restraints, due to aggression and agitation.
Coordinator - Resident Care # 105 confirmed that the resident was not assessed by BSO and not all alternatives to restraints had been considered or tried.

The scope of this area of non-compliance is isolated, there is previous non-related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 31. (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 alternatives to restraining the resident were considered and tried where appropriate, to be implemented voluntarily.

WN #9: 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, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, as required.

A review of the home's internal investigation report revealed that two PCPs reported to RPN # 108 that an identified resident was left unattended and secured to a device. Altered skin integrity to the resident was reported to RPN # 108.
There was no documented evidence that RPN # 108 assessed the area or completed a

head to toe skin assessment.

In an interview with RPN # 108, they said that the PCP told them about the area of altered skin. They said that the resident was not in distress so they informed PCP's # 110 and # 115 to let the evening RPN know.
RPN # 108 confirmed that they were aware of the change in skin condition and that they did not complete a skin assessment.

The home's Skin Care and Assessment and Wound Management policy and procedure, revised July 2014, directed staff under:
Section 3:
"All permanent Mount Hope residents and respite residents will receive a head-to-toe skin assessment performed by the RN or RPN:
On Admission (within 24 hrs.) and
Quarterly at the time of the three month medication review (for long term admissions) and
Any time there was a significant change in health or skin integrity status.
The head-to-toe assessment was to be documented in the electronic documentation system using the Head-to-Toe Skin Assessment tool".

Section 16: " For residents receiving daily hands on care from PCP staff, the PCP observed the resident's skin daily for reddened areas, actual or potential skin breakdown, rashes, open areas, blisters, skin tears, etc. Special attention should be paid to the sacral-coccygeal area, heels, hip bones, ankles, elbows and ears (especially for residents who frequently lie on their sides).
PCP's notified registered staff of any unusual findings".

Interview with Coordinator - Resident Care # 105 said that the expectation was that when a PCP reports to the RN or RPN any redness, rashes, skin tear, etc, the nurse would complete a skin assessment and it would be documented in Point Click Care (PCC).

Coordinator - Resident Care # 105 said that the expectation was that after the PCP reported the area of altered skin integrity, that the RPN would have completed a skin assessment on the resident.
Coordinator - Resident Care # 105 confirmed with Inspector # 523 that the nurse did not comply with the legislative requirement to complete a skin assessment when the resident exhibited altered skin integrity.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 50. (2) (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 a resident exhibiting altered skin integrity, including pressure ulcers would receive 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, to be implemented voluntarily.

WN #10: 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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
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 failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following were documented: the person who applied the device and the time of application and every release of the device and all repositioning.

A review of the home's policy Restraints: Physical, Chemical & Environmental, dated September 2013, directed staff in policy (#7) that "the nurse documented in the progress notes when a restraint was initiated and discontinued".

A clinical record review for resident # 020 revealed that restraint interventions were in place for an identified period of time.

The Coordinator - Resident Care # 105 said in an interview that those interventions had been in place as resident # 020 had behaviours since admission.
A clinical record review, with Coordinator - Resident Care # 105, revealed that the Point of Care (POC) task reports, over an identified period of time, had no assigned tasks for physical restraints.
Tasks were added at a later date.

A review of the progress notes, with Coordinator - Resident Care # 105, revealed that staff had documented applying restraints on some occasions but did not document when the restraint was removed.

Coordinator - Resident Care # 105 said that the home's policy Restraints, Physical, Chemical and Environmental directed staff in policy (#7) that "the nurse documented in the progress notes when a restraint was initiated and discontinued".
Coordinator - Resident Care #105 said that the policy had not been complied with and restraints had been applied without any documentation in tasks or progress notes.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [s. 110. (7)]

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 every use of a physical device to restrain a resident under section 31 of the Act is documented, including the person who applied the device and the time of application and every release of the device and all repositioning, to be implemented voluntarily.

WN #11: 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 had failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Observations, on June 15, 2016 at 1105 hours, on St. Mary's second floor revealed that the medication room door was unlocked and propped open by the drawer of the treatment cart. The medication room was unattended.
Inspector # 523 entered the room and found the medication cart was unlocked and medications in the cart were accessible.

During this time four residents, three visitors/volunteers, and two PCP's walked by the room.

At 1113 hours a resident came to the medication room. Inspector # 523 informed the resident that the inspector did not work at the home.

At 1115 hours inspector went out of the room, looking for the registered staff member. Registered Staff # 140 confirmed with inspector that the door was unlocked, open and unattended, as well as he/she was not aware that the inspector was in room or how long the inspector had been in the room.

Registered Staff # 140 said the expectation was for him/her to keep the medication room door closed and locked when unattended. [s. 129. (1) (a) (ii)]

2.Observation on June 22, 2016 at 1117 hours, on Marian Villa third floor revealed that the medication room door was unlocked, opened and unattended.

Medications placed on the shelves and treatment cart were accessible.

During this time several residents, non-registered staff and volunteers passed by the door.

RPN # 150 said in an interview that he/she did not know the inspector was in the med room or how long the inspector had been in the room. He/she said that the expectation would be to keep the door closed and locked when unattended.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 2, minimal harm or potential for actual harm. [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 were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
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. 104 (1).

Findings/Faits saillants :

1.The licensee failed to ensure the Director was informed of the analysis and follow-up action, including the immediate actions that were taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence, related to an alleged, suspected or witnessed incident of abuse.

A Critical Incident System (CIS) report was submitted related to alleged resident abuse, for an identified resident.

Under the analysis and follow-up section, regarding what immediate actions were taken to prevent recurrence, the home stated investigation to begin to review incident and under what long-term actions were planned to correct the situation and prevent recurrence, the home stated pending investigation.

An amendment to the CIS report was requested by a Triage Inspector at the Ministry of

Health and Long-Term Care. (MOHLTC)

During a review of the Long Term Care Homes Portal, there was no documented evidence that an amendment was completed by the home.

The Coordinator - Resident Care # 105 told Inspector # 137 that an amendment had not been completed and submitted, as requested and required by legislative requirements. [s. 104. (1) 4.]

2.The licensee failed to ensure the Director was informed of the analysis and follow-up action, the long-term actions planned to correct the situation and prevent recurrence, related to an alleged, suspected or witnessed incident of abuse.

A Critical Incident System (CIS) report was submitted related to alleged resident abuse, for an identified resident .

Under the analysis and follow-up section, regarding what immediate actions were taken to prevent recurrence, the home stated staff to monitor and under what long-term actions were planned to correct the situation and prevent recurrence, the home stated under investigation.

An amendment to the CIS report was requested by a Triage Inspector at the Ministry of Health and Long-Term Care. (MOHLTC)

During a review of the Long Term Care Homes Portal, there was no documented evidence that an amendment was completed.

The Coordinator - Resident Care # 101 told Inspector # 137 that an amendment had not been completed and submitted, as requested and required by legislative requirements.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the scope is determined to be a level 1, minimal harm. [s. 104. (1) 4.]

Issued on this 19th day of October, 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), ALI NASSER (523)
Inspection No. / No de l'inspection :	2016_217137_0014
Log No. / Registre no:	009790-14, 001938-16, 005693-16, 006355-16, 010088-16, 010999-16, 015709-16, 015871-16, 017034-16, 017180-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 29, Oct 20, 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. BOX5777, 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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8. s.19.
The plan must include what immediate and long-term actions will be undertaken to ensure that hourly checks are being completed on all residents, to determine each resident's whereabouts, at all times, as well as who will be responsible to ensure ongoing compliance.

Please submit the plan, in writing, to Ali Nasser, Long -Term Care Homes Inspector - Nursing, London Service Area Office, Ministry of Health and Long - Term Care, Long - Term Care Inspection Branch, , Long - Term Care Homes Division, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6B 1R8, by email, at Ali Nasser@ontario.ca by October 14, 2016.

Grounds / Motifs :

1. 1.For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg.79/10, s.5

A review of the Critical Incident System (CIS) report revealed that an identified resident was left unattended and secured to a device for an identified period of time, resulting in altered skin integrity.

The Coordinator - Resident Care # 105 said in an interview, with Inspector # 523, that through interviews and an internal investigation, it was determined that PCP # 113 was made aware that resident was left unattended, did not complete hourly checks on the resident and did not know if the resident was in their room or on the unit.
The Coordinator - Resident Care # 105 said the identified resident was neglected as they were left unattended and secured to a device for an identified period of time.
Coordinator - Resident Care # 105 confirmed that the resident was not protected from neglect by identified staff members on that shift.

A written notification and a voluntary plan of correction were previously issued on February 19, 2014, under Log # L-000188-14 and Inspection # 2014_228177_0001.

The scope of this area of non-compliance is isolated, there is previous related non-compliance and the severity is determined to be a level 3, actual harm. (523)

(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2016

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. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring the home is equipped with a resident-staff communication and response system that cannot be cancelled at the nurse's station or at any other location other than the point of activation.

Grounds / Motifs :

1. 1. On June 15, 2016 at approximately 1300 hours, Inspector # 523 observed a Personal Care Provider (PCP) deactivating the resident-staff communication and response system, on Marian Villa 2 (second floor), by lifting and replacing the telephone handset on the call bell intercom, which was located at the nurses' desk. Registered Practical Nurse # 108 stated the nurse call system could be cancelled at the nurses' desk.

On June 15, 2016 Inspector # 137 and Inspector # 523 observed the resident-staff communication and response system, on Marian Villa 2 (second floor) at 1338 hours and Marian Villa 4 (fourth floor) at 1347 hours, allowed calls to be cancelled at the point of activation, as well as by pressing the talk and listen button or "C" button on the call bell intercom and by lifting and replacing the

telephone handset on the call bell intercom, which was located at the nurses' desk.

Personal Care Provider (PCP) # 125 and Registered Practical Nurses # 108 and # 132 said the nurse call system could be cancelled at any of the four identified locations.

During a tour of the home, on June 15, 2016 at 1530 hours, the Director # 100 said the nurse calls, on Marian Villa, could be cancelled at any of the four identified locations and nurse calls should be cancelled only at the point of activation.

This legislation/regulation was previously issued:
- as a written notification and a voluntary plan of correction on January 5, 2016 under inspection # 2016_254610_0001- related to there was no resident-staff communication system in the front lounge
- as a written notification and a voluntary plan of correction on December 7, 2015 under inspection # 2015_260521_0057 - related to resident nurse communication not functioning in a resident's room
- as a written notification and a voluntary plan of correction on February 23, 2015 under inspection # 2015_264609_0010 - related to resident-nurse communication system not audible to staff
- as a written notification and a voluntary plan of correction on May 13, 2014 under inspection # 2014_242171_0007 - related to resident-nurse communication system not accessible and not functioning in a resident's room
- as a written notification and a voluntary plan of correction on September 4, 2013 under inspection # 2013_217137_0025 - related to resident-nurse communication system removed or access not provided to a resident.

The scope of this area of non-compliance is a pattern, there is previous related non-compliance and the severity is determined to be a level 2, potential for actual harm. (137)

(137)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must take action to achieve compliance by ensuring that all hazardous substances at the home are kept inaccessible to residents at all times.

Grounds / Motifs :

1. On June 15, 2016 at 1201 hours, the Trends Hair Salon door was observed open, the room was unattended and the lights were turned off. The Salon was located between the Wellness Centre, Café and in close proximity to the elevators, which are readily accessible to residents, visitors and staff. There were no residents in the Salon but residents were observed going to the other identified areas.
Hazardous substances were observed accessible to residents. Accessible, on the counter, were one container of comet cleanser, one container of sparkle and shine with ammonia, four bottles of Selsun medicated shampoo and one bottle of Denorex medicated shampoo.
Inspector # 137 observed an unlocked cabinet which contained Barbicide, Developer (Peroxide), room refresher, bathroom cleaner, several hair dyes and perm solution, one gallon bottle each of hair spray and disinfectant cleaner, one - one Litre container of rescue disinfectant and bleach powder.

A hairdresser # 154 said the room was only unattended at lunch time and was not aware the door had to be locked at all times when unattended.

The Director # 100 observed the Salon door open, unattended and that hazardous substances were accessible to residents. The Director # 100 also said that the door was to be locked at all times when unattended, to mitigate potential risk to residents.

This legislation/regulation was previously issued:
- as a written notification and a voluntary plan of correction on January 5, 2016 under inspection # 2016_254610_001
- as a written notification and a voluntary plan of correction on May 13, 2014 under inspection # 2014_242171_007

The scope of this area of non-compliance is widespread, there is previous related non-compliance and the severity is determined to be a level 2. (137)
(137)

2. Observations on June 16, 2016 at 1210 hours on Marian Villa (MV) third floor revealed that the door of Bathing Suite room # Z315 was left unlocked, open and unattended.
A bottle of Disinfectant Cleaner, a bottle of Tub, Basin and Tile cleaning solution were accessible to residents, as the Bathing Suite was located in the resident care area, in close proximity to resident rooms and the Bathing Suite door is in the hallway.
Inspector # 523 spent five minutes in the tub room and no staff member was in attendance or in visible vicinity.
Inspector approached RPN # 144 who confirmed the observation and said the expectation was to have the door to the tub room locked when unattended and all chemicals would be kept inaccessible to residents at all times.

The scope of this area of non-compliance is widespread, there is previous history of non-compliance and the severity is determined to be a level 2, potential for actual harm. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 29th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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