Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2017;	2016_457630_0045 (A1)	031087-16	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

AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The report was edited based on approved changes to the Compliance Order due dates for CO #001 & CO #002.

Issued on this 16 day of June 2017 (A1)

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

Original report signed by the inspector.

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

AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 5, 6, 7, 8, 9, 12, 13, 15, 16,19, 20, 21, 22, 23, 28, 29, 30, 2016 and January 3, 4, 5, 6, 9, 10, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Follow up to inspection 2016_254610_0001 including the following orders:

Follow-up log #004432-16/CO #001 regarding maintenance services;

Follow up to inspection 2016_217137_0014 including the following orders:

Follow-up log #033704-16/CO #003 regarding accessibility of hazardous substances;

Follow-up log #033706-16/CO #001 regarding duty to protect;

Follow-up log #033709-16/CO #002 regarding communication and response system;

Follow up to inspection 2016_226192_0022 including the following orders:

Follow-up log #033706-16/CO #001 regarding policy to prevent abuse;

Follow up to inspection 2016_2626523_0025 including the following orders:

Follow-up log #033710-16/CO #001 regarding skin and wound care;

Follow-up log #033711-16/CO #002 regarding responsive behaviours;

Follow-up log #033708-16/CO #003 regarding written agreements with physicians;

Critical Incident Log #021801-16/CI 596-000046-16 related to responsive behaviour;

Critical Incident Log #029533-16/CI 596-000069-16 related to alleged abuse;

Critical Incident Log #023641-16/CI 596-000050-16 related to alleged abuse;

Critical Incident Log #028456-16/CI 596-000062-16 related to alleged abuse;

Critical Incident Log #033747-16/CI 596-000097-16 related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Director, Coordinators of Resident Care, Assistant Coordinators for Resident Care, Administrative Assistant, Coordinator of Nutrition Services, Nutrition Managers, Registered Dietitians, a Diet Tech, Director of Facilities Engineering, Coordinator of Environmental Services, Director of Recreation and Volunteer Services, Infection Prevention and Control Practitioner, Pharmacists, Staff Educator, Occupational Therapist, Resident Assessment Instrument (RAI) Coordinators, Behaviour Support Ontario Staff (BSO), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aide, Recreation Care Aide, Housekeeping, Shipping and Receiving and Maintenance staff, Family, Residents' Council Representatives and over forty residents.

Inspectors also toured the resident home areas and common areas, medication

rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

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

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

24 WN(s)
8 VPC(s)
11 CO(s)
3 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 20. (2)	CO #001	2016_226192_0022	630
O.Reg 79/10 s. 50. (2)	CO #001	2016_262523_0025	523
O.Reg 79/10 s. 53. (4)	CO #002	2016_262523_0025	630
O.Reg 79/10 s. 82. (4)	CO #003	2016_262523_0025	630
O.Reg 79/10 s. 90. (1)	CO #001	2016_254610_0001	634

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. 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 all residents were protected from abuse by anyone.

a) A Critical Incident (CI) System Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which identified that a potential resident to resident abuse had occurred.

The clinical records for two identified resident showed that potentially non-consensual touching and behaviours had occurred between two residents.

The clinical record for one of the identified residents showed a history of behaviours and potential abuse of other residents prior to the reported CI. This record also showed no documentation of an assessment related to behaviours for this identified resident was completed by the physician until after the CI. The record showed no referrals had been made or assessments completed by the Behavioural Supports Ontario (BSO) program in the home prior to the CI. There was no involvement of external resources regarding the assessment of behaviours until after the CI. The plan of care for this identified resident did not identify triggers for potentially harmful interactions with other residents related to behaviours or ways to minimize the potential for touching of other residents.

During an interview with an identified staff member it was reported that prior to the CI they were not aware of any incidents of this identified resident having inappropriate behaviours towards other residents or aware of potential triggers for the behaviours.

During an interview with another identified staff member it was reported that there had been incidents of this identified resident touching other residents prior to the CI. This staff member reported they had received training on the prevention of abuse and neglect. This staff member said that previous incidents of touching between this identified resident and other residents seemed to have been consensual but said that it was difficult to determine. This staff member said they could not recall specific training that they had received and they needed further education in the home.

During an interview with the Coordinator Marian Villa (MV) and the Coordinator Assistant MV it was reported that the home did not have a policy to direct staff regarding behaviours and a specific assessment related to this behaviour as this would be covered by the home's policy on the prevention of abuse and the Resident's Bill of Rights. They reported this identified resident had a history of inappropriate behaviours with other residents prior to the reported CI. The Coordinator MV said that there should have been assessments completed and

more interventions put in place to help minimize the risk for abuse. (630)

b) The following is further evidence to support Compliance Order #001 issued on June 7, 2016, in inspection #2016_217137_0014, with a compliance date of November 10, 2016.

A Critical Incident (CI) System Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which identified that a potential resident to resident abuse had occurred. This report identified "a history of inappropriateness" for both identified residents.

The clinical records for these two identified resident showed that there had been multiple incidents of potentially non-consensual touching and behaviours between the two residents and with other residents. The plans of care for both identified residents did not identify triggers for potentially harmful interactions with other residents related to behaviours or ways to minimize the potential for touching of other residents.

During an interview with an identified staff member it was reported that there had been incidents prior to the CI. This staff member reported they had received training on the prevention of abuse and neglect. This staff member said that previous incidents of touching between this identified resident and other residents seemed to be consensual but that was difficult to determine. This staff member said they could not recall specific training that they had received and there was a need as further education in the home related to this behaviour.

During an interview with the Coordinator Marian Villa (MV) and the Coordinator Assistant MV it was reported that the home did not have a policy to direct staff regarding specific behaviours and a specific assessment related to this behaviour as this would be covered by the home's policy on the prevention of abuse and the Resident's Bill of Rights. They said to their knowledge they had not been informed by staff of prior incident of potential resident to resident abuse related to these residents prior to the reported CI. The Coordinator MV said that there should have been assessments completed and more interventions put in place to help minimize the risk for abuse.

During an interview with the Director of Mount Hope it was reported that they did not have a specific way to assess but would consider Cognitive Performance Scale (CPS) . The Director said that in the home any consensual or non-consensual

touching would be dealt with in the same way and would be considered possible abuse.

The severity was determined to be a level three as there was actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 26, 2016, in Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (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, which was in place in the home until September 27, 2016, titled "Abuse and Neglect of Residents: Zero Tolerance" and "Original Effective Date August 2001; Revised Date July 2014" included the following procedures:
6. "When an incident of alleged, witnessed or suspected abuse or neglect of a resident occurs it is mandatory that the person who becomes aware of the abuse report the incident immediately to the RN; in the evenings, at night or on weekends the RN informs the Clinical-on-call; the RN will call the Coordinator so they can inform the Ministry."
9. "The Coordinator of Resident Care will fully investigate any alleged, witnessed or suspected abuse immediately. This may be done by interviewing all relevant parties, examining documentation or other evidence, or by directing a designate to do so."
10. "When possible the Coordinator/Clinical-on-Call or their designate will ask staff or others who have witnessed or have knowledge of the suspected abuse or neglect to provide individual statements, independently of each other, describing the detail of what occurred."

a) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which reported an alleged incident of staff to resident abuse.

The clinical record for an identified resident showed their family member had reported a concern to a staff member regarding an alleged abuse incident.

During an interview the Assistant Coordinator Marian Villa (MV) said that the staff working on the date of the CI had not notified the Clinical Registered Nurse (RN) or called the manager on call immediately after having been made aware of an alleged incident of staff to resident abuse. Assistant Coordinator MV said that the investigation into the alleged abuse was not started immediately. The Assistant Coordinator MV said they had informal conversations with the staff working on that floor regarding the family's concerns but they did not ask staff if they had witnessed any abuse or document interviews with staff regarding the alleged incident. The Assistant Coordinator MV acknowledged that the home's policy to promote zero tolerance of abuse as it related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse was

not complied with. Assistant Coordinator MV said it was the expectation in the home that the policy would be followed and all staff in the home had recently be retrained on a revised version of the policy to promote zero tolerance of abuse. (630)

b) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which reported an alleged incident of resident to resident abuse. This report stated that a previous incident had occurred between these two identified residents.

The clinical record for an identified resident showed previous incidents of touching between these two residents prior to the CI which had been documented in the internal incident reports.

During an interview with the Coordinator MV they said that they thought there had been no reported incidents of alleged abuse between two residents prior to the CI. Coordinator MV said that the home's internal incidents reports were not reviewed immediately by the management staff and this was not how the staff in the home were to immediately notify the management of alleged abuse. The Coordinator MV said the expectation in the home was that any type of touching between residents would be reported to the Coordinators as potential abuse and investigated as per the policy. Coordinator MV acknowledged that there had been past incidents of touching and behaviours between residents identified in the internal incident reports and progress notes that had not been dealt with as per the policy. Coordinator MV acknowledged that the staff had not reported the potential abuse to management as per the home's policy and there had not been immediate investigations completed.

During an interview the Director of Mount Hope said that the only policy related to touching was encompassed within the prevention of abuse policy and there was no other policy that it would fall under to direct staff regarding the assessment of touching and behaviours of residents. The Director of Mount Hope said that they thought they did not have a specific way to assess residents related to these behaviours but they would consider the Cognitive Performance Scale (CPS). The Director of Mount Hope said consensual or non-consensual touching would be dealt with in the same way in the home and would be considered possible abuse and should be dealt with as per the policy on prevention of abuse and neglect. (630)

c) The clinical record review for an identified resident showed a history of behaviours towards other residents. This clinical record showed an incident of potentially non-consensual behaviours and touching that occurred between this identified resident another resident.

During an interview with the Coordinator MV they said that they were not aware of any incident of alleged abuse between this identified resident and other residents in the home. The Coordinator MV checked the internal incident reporting system and noted that there was no record of the incident. The Coordinator MV said that the staff did not report the incident to the charge RN and therefore the charge RN and the management had not been made aware of the incident. The Coordinator MV acknowledged that the home's policy called "Abuse and Neglect of Residents" was not complied with related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse. (523)

d) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which was identified as an "incident that caused an injury to a resident for which the resident was taken to hospital" but did not identify alleged "staff to resident abuse." This report stated that the identified resident had told staff that a staff member had hurt them.

The clinical record for an identified resident showed that at the time of the CI the resident had reported to staff that they thought that a staff member had hurt them.

During an interview with the Coordinator MV it was acknowledged that the policy for prevention of abuse and neglect was not followed for this CI related to the alleged abuse as they had not fully investigated and did not have documented written statements from the staff involved.

Based on the review of these critical incident reports, interviews with staff and management in the home and review of the clinical records including the home's internal incident reporting system the licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, that was in place at the time of the incidents, was complied with related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course

of this inspection. There was a compliance history of this legislation being issued in the home on January 7, 2016, in a Complaint Inspection #2016_260521_0002 as a VPC, on May 26, 2016, in Critical Incident Inspection #2016_226192_0022 as a Compliance Order (CO) and a Director's Referral (DR), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home has failed to ensure that any elevators in the home were equipped to restrict resident access to areas that were not to be accessed by residents.

Multiple observations over the course of the Resident Quality Inspection found that

the elevator leading to the basement of the home enabled residents to access multiple rooms and areas that were not to be accessed by residents.

On December 9, 2016, at 1237 hours it was noted that there was a tunnel that connected both St. Mary's and Marian Villa home areas to the St. Joseph's Hospital. The service elevator in alcove Z028 on Marian Villa side was taken by Inspectors #523, #532 and #659 and it was noted that the elevators were opening up to the resident home areas. The Inspectors took the service elevator from the basement to the Marian Villa Third Floor and noted it opened onto the resident home area. The Inspectors then took the elevator back to the main floor and the rear door of the elevator opened to the main kitchen.

On December 9, 2016, tour of the basement completed by Inspectors #523, #532 and #659 found the following:
- A stairwell leading to an unlocked door which exited to the outside and this was labelled as "Emergency Exit".
- "Ladies Locker Room", "Men's Locker Room" and "Bathroom" were unlocked.
- An unlocked door leading to a stairwell which led to an additional stairwell.
- "Mechanical Room" door was unlocked which led to the "Boiler Room" and there was an unlocked door inside of this room documented as "4, 160 volts".
- An unlocked door "B-002" which was documented as "Authorized Personnel Only"
- An unlocked door "VB-46" to food services area.
- An unlocked door "VB-24" "Mail Room" with a signed which stated "Please do not lock".
- An eye wash station was located in hall with "Virex", "Crew" bathroom cleaner and

scale remover, "Glance HC" glass and multi surface cleaner and "Stride" fragrance free SC neutral cleaner, broken glass and florescent lights were sitting in an open bin.
- The automatic doors leading to the loading dock were unlocked.
- An unlocked door "VB18" receiving doors and was observed to be open.
- An unlocked door "WB05" "Laundry Room" with laundry detergent.
- A family member was observed pushing a resident in a wheelchair through the basement hall.

On December 9, 2016, at 1247 hours an identified staff member told the Inspectors that often people got lost coming out of parking garage and ended up in the tunnel. This identified staff member said that staff, visitors and clients took the basement

tunnel. An identified staff member said that there were residents who would use the tunnel. This staff member said that the door to the food service area was usually open until 1430 hours.

On December 9, 2016, an identified staff member said the doors should have been locked and acknowledged that room "B023" was unlocked at the time of the interview.

On December 9, 2016, at 1345 hours the Director of Mount Hope accompanied Inspectors #523, #532 and #659 on a tour of the basement. The Director of Mount Hope said that residents did not usually access the basement but there were residents who did use the tunnel from the basement. They said they were aware that residents accessed the tunnel. The Director of Mount Hope acknowledged the immediate risk for resident safety.

On December 9, 2016, at 1500 hours, the Director of Mount Hope and the Facility Coordinator (FC), contacted the Inspectors and shared that they were working on a plan to address the safety concerns with the doors. The FC said that the plan was to put a card reader on the double access door in the Marian Villa side of the basement. The FC said that on December 12, 2016, they would make a "rush order". The FC said they were also planning to put an access card reader on the service elevator and they were going to ensure all doors were closed and no residents would be able to access these areas. Director #100 said that a communication was going out to staff to reiterate the importance of completing the hourly checks to ensure residents were accounted for.

On December 12, 2016, at 1230 hours, Inspector #630, #659 and #532, noticed that room "B002" marked as "Authorized Personnel Only" was open and not locked.

On December 13, 2016, at 1200 hours Inspector #532 took elevator from the Marian Villa side down to the basement. It was observed that the main door to enter the basement was open, and the doors leading to the "Male Locker Room" and "Female Locker Rooms" were unlocked, the "Emergency Exit" door leading outside was unlocked and the "Shipping and Receiving" doors were unlocked. The Inspector also observed residents and families taking the basement tunnel to go to St Joseph's hospital.

On December 15, 2016, at 1200 hours Inspectors #532, #630 and #659 took

elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked, the "Mechanical Room" "B-012" was unlocked, and "Shipping and Receiving" doors were unlocked.

On December 15, 2016, the Director of Mount Hope was asked about the doors in the tunnel and they stated that they had not spoken with the Director of Facility (DOF) since December 12, 2016.

December 20, 2016, at approximately 1200 hours, Inspector # 659 and #630 observed that the "Emergency Exit" door leading to the outside was not locked.

On December 21, 2016, at 1200 hours, Inspectors #659, #630, #634 and #523 took elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked, the "Male Locker Room" and "Female Locker Rooms" were unlocked, and the "Shipping and Receiving" doors were unlocked.

On December 21, 2016, at 1529 hours, Inspector #523 observed a resident walking alone with their walker in the tunnel near the shipping doors.

On December 22, 2016, at 1330 hours Inspectors #659, #532, #630 and #634 took the elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked and the "Male Locker Room" and "Female Locker Rooms" were unlocked.

On December 22, 2016, at 1435 hours the Director of Mount Hope, the Facility Coordinator (FC) and the Director of Facility (DOF) accompanied Inspectors #523 and #532 on a tour of the basement. Observed the door by the elevator Z0-E04 north door was locked and staff were using the key to get in and out of the door. The DOF acknowledged that the locking of the door had been implemented just prior to the tour. The DOF said that the locking of the door was part of an immediate plan to have the north door locked. Inspector #532 identified to the management that the door by the elevator leading to the basement was found to be unlocked on multiple occasions during the inspection. The DOF said that they wanted to implement an action plan right away, however, it took time to get the parts for the lock. The DOF said from that point on the basement would be under complete lock down as they had locked all the doors and there was no access to the basement.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 10. (1)]

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 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 allowed calls to be cancelled only at the point of activation.

On September 29, 2016, inspection number 2016_217137_0014, CO #002, the licensee was ordered to take action to achieve compliance by ensuring the home was equipped with a resident-staff communication and response system that could not be cancelled at the nurse's station or at other locations other than the point of activation. This order was to be complied with by November 10, 2016.

Observations by Inspector #523 on Marian Villa Second Floor found the resident-staff communication and response system signalling at the nursing station and an identified staff member was at the nursing station at the time. Inspector #523 asked the staff member if staff were able to cancel the signal from the nursing station they said "no". Inspector #523 observed holes in the glass cover over the resident-staff communication and response system. Inspector #523 went to an identified room and activated the response system and then Inspector #523 was able to deactivate the signal using a pen through the hole while in the presence of the staff member. The staff member then said that staff were able to deactivate the signal at the nursing station but said that they did not think that staff would do that.

During an interview the Director of Mount Hope told Inspector #523 that it was possible for staff to deactivate resident-staff communication and response signals from the nursing station not just at the point of activation.

Review of Work Order 2007244305 indicated "change all pexi glass covers on all levels of Marian Villa" with date completed December 7, 2016.

During an interview the Director of Mount Hope told Inspector #630 that they changed the type of cover that was over the resident-staff communication and response system on December 7, 2016, as the previous cover did not ensure that staff could not deactivate the system from the nursing station.

The severity was determined to be a level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 5, 2016, in a Resident Quality Inspection #2016_254610_0001, as a Voluntary Plan of Correction (VPC), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO). [s. 17. (1) (c)]

2. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Inspector #630 observed that the call signalling for a room in Marian Villa was audible only from the resident-staff communication and response system intercom at the nursing station.

During an interview with a staff member it was reported to Inspector #630 that the only place the signal was audible was from the resident-staff communication and response system at the nursing desk. This staff member said it should have been signalling from the black phone down the hallway but it was not audible from that phone at that time. This staff member said that staff could adjust the volume on the phones.

Inspector #630 and #523 observed on Marian Villa Third and Fourth Floors that the black phone outside resident rooms, which were the auditory part of the resident-staff communication and response system, had the volume turned down or off. Inspectors #630 and #523 were able to turn the volume off and on using this black phone. It was also observed that not all hallways had black phones.

During an interview with another staff member it was reported that when a resident had activated a call bell the staff would hear the signals on the black phones in the hallways and from the main panel at the desk. This staff member said that there were times when they could not hear the call bell if they were in another room especially the end rooms. This staff member said that sometimes the night staff would turn the volume down or turn off the ringer. This staff member also said the resident-staff communication and response system was hard to hear when they were in rooms providing care. Inspector #630 and #523 went into a specified resident room in Marian Villa with this staff member and the call bell was activated and the system could not be heard.

During an interview with another staff member it was reported to Inspector #630 and #523 that staff could turn off the volume on the black phones and then staff would only be able to hear the signals at the desk. This staff member also said that residents would play with the phones at times and turned down the volume. This staff member said there were rooms that staff could not hear the resident-staff communication and response system and it needed to be louder.

An identified staff member observed with Inspectors #630 and #523 that the call bell for a specific resident room in Marian Villa was signalling and was not heard in the room. This staff member pulled the cord out and could not hear the signal. This staff member said the staff did not carry pagers and that there was no black phone in the hallway in that area. This staff member said they looked for the flashing light on the wall to identify that a resident was signalling for assistance. This staff member said that they also relied on the registered staff at the desk to notify them of a signal if they did not see it.

During an interview the Director of Facilities (DOF) told Inspector #630 that it was their understanding that the black phones were not an essential part of the resident-staff communication and response system. The DOF said that staff could hear the signals from the intercom at the desk from anywhere on the floor. The DOF said they tested the resident-staff communication and response system to ensure the signals were auditory when they put the plastic covers over the intercom at the desk. The DOF said they tested all floors and they determined it could be heard in all areas.

Inspectors #532, #523 and #630 with the Director of Mount Hope, the Facility Coordinator (FC) and the DOF toured Marian Villa Third Floor and observed the phone in the hallway beside an identified resident room. DOF acknowledged the phone was able to have the volume turned off. Inspector #523 activated the resident-staff communication and response system in a resident room and the Director and the FC acknowledge that the call bell was not audible from the nursing station and the phone was not making any sound. The DOF said the home needed to come up with a plan to ensure that staff could hear the call system in the hallway.

Inspectors #532, #523 and #630 toured Marian Villa Fourth Floor with FC. Standing in hallway outside a specified resident room there was a resident signalling for assistance and it was not audible in this hallway. The FC indicated that they identified that the resident-staff communication and response system was not auditory in all areas not just due to the black phones not being able to be heard but also because the volume of the intercom at the nursing station was not high enough. The FC said they needed to look at improving their call response system.

The severity was determined to be a level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. The home

does not have a history of non-compliance in this subsection of the legislation. [s. 17. (1) (g)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Review of the clinical record for an identified resident showed they had a history of responsive behaviours. The clinical record did not include assessment of resident's history of behaviours or potential triggers, no written screening protocols, assessments, reassessments or the identification of behavioural triggers that had been completed. Further review of the Patient Safety Reporting System (PSRS)

forms completed for responsive behaviours for this resident found that not all incidents described in the progress notes had a PSRS completed.

During an interview with an identified staff member it was reported that at the time of the inspection the home was working to improve the Behavioural Supports Ontario (BSO) program in the home. This staff member said any assessments that had been completed for this identified resident would have been in the hard copy of the chart. This staff member said that staff on the floors used their discretion as to when to refer to the BSO in the home. They also said the BSO team then would use their discretion as to when to refer to external specialized resources but there was not written protocols within the home regarding these referrals.

Review of the home's policy titled "Resident Aggression and Responsive Behaviours" and "Revised Date April 2016" indicated the following:
- "All incidents involving responsive behaviours are documented in the residents chart as well as in the on-line PSRS." The policy did not identify who was responsible for monitoring the PSRS sheets.
- "Behavioural flow sheets used to track behaviours over time and according to time of day and event may be used to identify patterns of behaviour and the triggering events for behaviour." The policy did not provide further guidance as to which staff were to use the flow sheets, when to use the flow sheets, and which flow sheets to use or other screening tools or assessment tools that were to be used regarding responsive behaviours.

On December 20, 2016, Coordinator MV told Inspectors #630 and #523 that they were working with external resources to revise and improve the program in the home to manage responsive behaviours which included working to improve the BSO program. The Coordinator MV acknowledged the program in place at the time of this inspection did not contain written protocols for screening residents, assessments including the assessment tools that were to be used, protocols for referring to the internal BSO or external services. The Coordinator MV said that the program needed improvement in terms of the written strategies in the home for responsive behaviours.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016, in Complaint Inspection #2016_262523_0025 as a Compliance Order. [s. 53. (1) 1.]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Review of the clinical record for another identified resident showed that this resident had a history of responsive behaviours.

During interview with multiple staff over the course of the inspection it was reported that this identified resident had been inappropriate with staff and had responsive behaviours.

During an interview with a staff member who worked with the BSO program it was reported that they did not receive any referrals for the resident related to any responsive behaviours. This staff member said that these behaviours expressed by the resident required a referral to the BSO team for assessment and determining interventions.

During an interview with Coordinator MV it was reported that the resident should have been referred to BSO team given that responsive behaviours continued to occur despite the initial interventions. Coordinator MV said that they would discuss it with the team to ensure that if responsive behaviours continue and initial interventions were not successful that they need to refer to BSO.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016, in Complaint Inspection #2016_262523_0025 as a Compliance Order. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 at the home were kept inaccessible to residents at all times.

On September 29, 2016, inspection number 2016_217137_0014, CO #003, the licensee was ordered to take action to achieve compliance by ensuring that all hazardous substances at the home were kept inaccessible to residents at all times.

On December 9, 2016, Inspectors #523, #532 and #659 observed that the basement in Marian Villa was accessible by residents through the service elevator. The inspectors also observed an unlocked housekeeping cart in the basement with unsecured chemicals. The inspectors observed the following unlocked areas which contained hazardous substances:
- The "Mechanical Room" door "B-012" had spray paint cans.
- The "Laundry Room" in basement was unlocked with chemical detergent named "Clax Assist".
- The "Shipping and Receiving Room" unlocked with Virox, "Crew" bathroom cleaner and scale remover.
- The basement hallway unlocked with "Glance HC" glass and multi-surface cleaner, "Stride" fragrance free, "SC Neutral Cleaner".

On December 9, 2016, the Director of Mount Hope toured the basement with Inspectors #523, #532 and #659 and acknowledged the basement was accessible to residents and hazardous substances at the home were accessible to residents.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order. [s. 91.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

An identified resident was listed as being at high nutritional risk by the Registered Dietitian (RD).

Review of the nutritional intake and snacks as documented on Point Click Care

(PCC) showed this resident refused multiple meals and snacks during a specific time period.

The clinical record also showed a significant weight loss occurred in a specified time period and the resident was below their goal weight range that had been established by the home's RD. There was no referral to the RD related to the self/adaptive aids required/limited assistance with feeding.

During an interview the Director of Mount Hope and the Director of Food and Nutritional Service (DFNS) initially stated that they were not familiar with who was responsible for monitoring the fluids and nutrition intake at the end of the shift or day to ensure residents met the minimum target intake requirements. Later the Director of Mount Hope stated that monitoring of the resident’s nutritional intake would be done by the Registered Dietitian (RD) as part of the quarterly assessments. At other times during the quarter the Personal Care Provider (PCP) or nurse should be monitoring the resident’s intake and they could put a referral into the RD if needed.

During an interview with the RD they said they did not recall having been made aware of this resident's refusal of food as it was up to the staff in the area to notify the RD of any changes.

During an interview with the Dietary Technician (DT) they stated that the night nurse created alerts to the RD for low fluid intake and they said they may on occasion do the same for nutritional intake but they did not think that the nutritional intake was monitored.

The home’s policy titled “Nutrition Assessment, Reassessment, Care Planning, Documentation, Follow up” with “Revised August 2015”, documented that if nursing staff would like the resident assessed from a nutrition point of view at any time during their stay, or would like to initiate diet changes, etc. a consult to the RD/DT could be communicated at any time. This policy did not include direction regarding a referral to the Registered Dietitian's in response to a resident’s altered nutritional intake. The licensee’s policy related to nutrition and hydration management addressed monitoring related to fluid intake, but not related to nutritional intake.

During an interview with the Coordinator Food and Nutrition Service they stated that there was no procedure for monitoring the nutritional intake of residents.

The licensee failed to ensure that there was a system to monitor and evaluate the food intake of residents with identified risk related to nutrition and hydration.

The severity was determined to be a two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection since the home did not have a system in place to monitor and evaluate food intake of all residents with identified risk related to nutrition. The home does not have a history of non-compliance in this subsection of the legislation. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 009

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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 plan of care set out clear directions to staff and others who provide direct care to the resident.

The plan of care for an identified resident included the issue of bladder incontinence. The plan of care identified that this resident required limited assistance from staff. This plan of care did not provide direction regarding continence care products.

During an interview with an identified staff member they reported that this resident was incontinent at times, was toileted by staff routinely and wore a specific continence care product.

The Resident profile worksheet and the PCP Shift Routine identified the resident as being continent for bowel and bladder.

During an interview with another staff member they reported that they were not aware of the continence level for this resident but they would check the plan of care. This staff member reviewed the PCP daily assignment sheet, the Minimum Data Set (MDS) and continence assessments and the plan of care, and said that the plan of care did not seem to give clear direction regarding the resident's continence care needs.

Inspector #523 reviewed the daily assignment sheet with another staff member and it identified that this identified resident was continent of bladder and bowels. This staff member said that the assignment sheet was incorrect and that they would notify the RPN that the plan of care needed to be updated.

During an interview with another staff member it was reported that the continence care product sheet that was in use at the time of the inspection showed that the resident was continent and did not use any continence care products and that the resident was continent.

During an interview with Coordinator Saint Mary's (SM) they said that the plan of care did not set out a clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

a) Clinical record review for an identified resident had stated preferences in an assessment section for Therapeutic Recreation. The plan of care for this resident did not include interventions based on the resident's preference.

During an interview with an identified staff member it was reported that the resident's previous preferences and interests were considered during the development of the plan of care and determining the activities that the resident would be involved in. This staff member said that the plan of care in regards to recreational and social activities was not based on the resident admission assessment.

During an interview the Coordinator of Recreational and Social Activity Programs they said that it was their expectation that the resident's plan of care and current activities were based on previous preferred activities as identified in the admission assessment. The Coordinator of Recreational and Social Activity Programs said that the plan of care for this resident was not based on their recreational and social preferences. (523)

b) A physician's order documented that an identified resident preferred a specific device for care.

Observations completed during the inspection showed that this resident did not have this specific device in place.

This resident verbalized to Inspector #659 a preference for this specific device.

During interviews with identified staff it was reported that residents who were not ambulatory were not provided with this specific device.

During interviews with other identified staff they reported they were not familiar with this resident's preference to use this device.

In an interview with Assistant Coordinator SM they stated that there was no reason why this resident could not use the specific device and the expectation was that staff respect a resident's preference and provide care as specified in the plan of care. (659) [s. 6. (2)]

3. The Licensee failed to ensure that care was provided as specified in the plan of care.

a) Review of the clinical record for an identified resident showed they required a specific level of assistance with personal care.

The resident's plan of care documented that staff were to ensure that the resident had a specific type of personal care provided after meals and at night.

Review of documentation for a specific time frame showed documentation for this personal care was completed twice a day.

Inspector #659 observed that this resident did not receive the personal care listed

in the plan of care during a specific time period.

During interviews with this resident they stated that staff assisted with this personal care once a day.

During interview with staff they reported they provided the care twice daily.

During an interview with another staff member they stated that it was too much to provide the personal care as specified in the plan of care.

The Coordinator SM stated that the expectation was that staff would follow the plan of care. (659)

b) Clinical record review for an identified resident showed care plan interventions that included use of a specific device for positioning an safety.

A clinical record review stated that this resident was to have this device checked at specific time frames. A further review of the report for a specific time frame found that eight per cent of the tasks were not signed.

In an interview Coordinator MV they said that the staff were expected to ensure care in the plan of care was delivered and checks were completed and signed for. Coordinator MV acknowledged that the checks were not signed for and could not confirm if the tasks/care from the plan of care were completed. (523)

c) Observations of an identified resident during a specific time period showed they were using a specific device and the device appeared to be applied incorrectly.

Observations made on with an identified staff member showed that this device was applied incorrectly. This staff member said this was unacceptable as it was a potential risk to the resident.

The plan of care in place for this resident at the time of the inspection showed that this resident had a specific device. This also stated that staff were to monitor routinely for safe and proper positioning and remove.

An identified staff member told Inspector #523 that they did routine checks at certain intervals on residents and ensured that devices were applied correctly. This staff member said that they went to check on the device. This staff member was

observed placing this specific device back onto the resident and it continued to be applied incorrectly.

Assistant Coordinator MV checked the specific device and said that it was not applied correctly. They were then observed to adjust the device.

In an interview with the Occupation Therapist (OT) they said that the device should be applied correctly and that this was an inappropriate application of the device.

During an interview Coordinator MV they said that they were made aware that the devices were applied incorrectly. They said that the home's expectation was that when staff complete the checks on residents with these devices that they ensured they were applied correctly.

Based on these observations, interviews and clinical record review the care set out in the plan of care, was not provided to the resident as specified in the plan for the specific device. (523)

d) During a clinical record and plan of care review with an identified staff member they stated that the goal was to have an identified resident engaged in a minimum of four activities per week.

A review of the monthly report showed the following activities completed as follows:
September 2016: nine activities per month.
October 2016: three activities per month.
November 2016: four activities per month.
December 2016: two activities per month.

This staff member informed Inspector #523 that the plan of care and required goals were not being followed and the care set out in the plan was not being provided.

Coordinator of Recreational and Social Activity Programs (RSAP) said in an interview that the expectation was that the resident would attend activities as indicated in the care plan. They said if the resident refused or was busy then staff were to document this. The Coordinator RSAP identified that they already had an action plan in place to address this concern. (523) [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's nutritional care needs changed.

An identified resident was assessed by a Registered Dietitian (RD) as being at "High Nutritional Risk" due to a specified reason.

The clinical record showed this resident had a weight loss and the resident's weight was below their goal weight range.

The plan of care for this resident for "eating" documented that staff provided a specific level of assistance. The interventions included that PCP's were to report to registered staff any decrease in resident's ability to participate in eating activity. The plan of care for the resident also indicated a specific type of adaptive aid was to be used during meals and snacks.

Review of the assistance provided for nutritional intake and snacks documented on POC for this resident showed the resident was receiving a different level of assistance than what was identified in the plan of care for eating.

Observations during specified meals found the staff providing a different level of assistance to the resident than was identified in the plan of care. The resident was observed not to be using the adaptive aide that was included in the plan of care.

During interviews with multiple staff they stated that the resident had deteriorated and required an increased level of assistance with eating.The staff said they were not aware that the resident required the adaptive aide and acknowledged that this adaptive aid had not been used with this resident.

Based on these interviews and the clinical record review the plan of care for this resident was not revised when the resident's nutritional care needs changed. (659)

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2014_326569_0009 as a VPC, January 5, 2016, in a Complaint Inspection #2015_228172_0001 as a VPC, June 9, 2015, in a Complaint Inspection #2015_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, May 26, 2016, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR) and June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 010, 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of every resident to be afforded privacy in caring for his or her personal needs was fully respected and promoted.

Inspector #630 observed an identified resident at a specific time being dressed by two staff members in the doorway of a shower room of the home. This resident was observed with their pants down around thighs and skin was exposed around groin and hips.

During an interview with the staff member they acknowledged the resident was being changed in the doorway. This staff member said they thought they had a towel covering the resident for privacy. This staff member acknowledged the care they provided did not provide privacy to the resident during personal care.

Review of the plan of care for this resident showed they required assistance for dressing.

During an interview with Coordinator SM they said that it was the expectation in the home that residents would not be changed in the doorway of the shower room in order to maintain their dignity and privacy of a resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 15, 2015, in an Inspection #2015_228172_0004 as a VPC. [s. 3. (1) 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 every resident's right to be treated with courtesy and respect and in a way that fully promotes their individuality and respects their dignity; right to be properly groomed and cared for in a manner consistent with his or hers needs; and right to be afforded privacy in caring for his or her personal needs are fully respected and promoted, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On December 5, 2016, observation during the initial tour found that room W144 was under construction and the door to this room was open and unattended, plastic barrier was partially taped across the outside of the door and there were several tools in the room.

On December 5, 2016, observation during the initial tour found room W124 was under construction, door to this room was unlocked and unattended with plastic barrier partially taped across the outside and two chairs placed in front of the door and tools were present.

On December 5, 2016, Coordinator SM said that the doors to W124 and W144 should have been closed when unattended due to the risk associated with materials and tools. In the meantime the two construction workers came and Coordinator SM informed them to keep the doors locked and closed when unattended.

The Director of Mount Hope acknowledged that the doors to W124 and W144 were unlocked, opened and unattended. They said that the expectation was to keep the door locked and closed when unattended.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC. [s. 9.]

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 are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Findings/Faits saillants :

1. The licensee has failed to ensure that when a Personal Assistive Services Device (PASD) under subsection (3) was used to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would
not be, or have not been, effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by a physician,
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Clinical record review for an identified resident had a specific device implemented as part of their care at the time of admission. The clinical record showed that the order was updated in the plan of care and verbal consent was given on a different date than when the device was implemented.

During interviews with multiple staff they reported that this resident was using the specific device since admission.

During an interview with another staff member they acknowledged that the specific devices that were in place were PASDs with restraining qualities; they shared that they would not use specific devices without trialling alternative methods first. This staff member was not able to provide evidence that they had trialled different

alternatives before using the devices. This staff member was not able to find any assessments for the use of the device on admission or if other alternatives were used. This staff member told Inspector #523 that the plan of care interventions for use of this device were dated after admission. This staff member reported that there was not documented evidence that the resident had different alternatives trialled before the PASD was implemented.

Inspector #523 reviewed the above information with Coordinator MV related to use of the specific devices. Coordinator MV acknowledged that this was not acceptable as PASD alternative should have been trialled and the plan of care updated accordingly.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 33.]

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 when a PASD under subsection (3) is used to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied: alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living; the use of the PASD has been approved by a physician; the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent; the plan of care provides for everything required under subsection (5), to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident was assessed following a weight change of 7.5 percent of weight or more over one month and 10 per cent of body weight over three months.

Clinical record review showed that this resident had been ordered a specific diet texture upon admission and this was changed at the request of the family. Admission nutritional assessment was completed by a RD for this resident and indicated the resident was "High Nutritional Risk" for a specific reason.

The clinical record showed that the resident had a significant weight loss in a specified time period and was below their goal weight range that was established by the home's RD.

Review of the nutritional intake and snacks as documented on Point Click Care (PCC) showed multiple meal and snacks were refused during a specific time period for this identified resident.

Review of the clinical record for this resident found there was no nutritional re-assessment completed.

During an interview with an identified staff member they stated that the RD usually notified them if a reweigh was required. The staff member stated that the RD would come quarterly to the unit to assess the residents and they believed that the RD

assessed the residents around when the quarterly was due.

During an interview with the Registered Dietitians (RD) they stated that the RD assessed the resident upon admission to the home and then quarterly if they were a high risk. They stated they monitored residents in the electronic documentation system for any weight loss. If a resident had more than five per cent weight loss then it was the PCP's job to reweigh the resident immediately. It was a combination of nursing and the RD to ensure the reweigh was completed. They stated that there were current delays in resident assessments and that there was no set time frame for reassessment of a resident with weight loss. They stated that they complete reassessment when they could. They also stated that they prioritized the work as first they completed the admission and quarterly assessments and then they completed the assessment of those residents with weight loss.

The licensee failed to ensure that the resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated following this resident weight change of 7.5 percent of weight or more over one month and 10 per cent of body weight over two months.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are assessed following a weight change of 7.5 per cent of weight or more over three months and 10 per cent of body weight over six months, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident was provided with assistive devices to safely eat and drink as comfortably and independently as possible.

An identified resident was documented as using a specific item for drinking when they were admitted to the home.

The Registered Dietitian (RD) assessed this resident and documented in the plan of care that the resident required another specific assistive device for drinking.

During interviews with multiple staff they indicated that the resident did not use the one type of assistive device and instead the resident used a specific item to drink their fluids.

During an interview with the RD they said it was documented for each resident if an assistive device was required. The Dietary Technician (DT) stated that an Occupation Therapy (OT) referral would have been put in and OT would review the referral and supply the assistive device and then the Dietary Aide would be responsible to ensure the device was available.

Observations completed at specific meals during the inspection showed that this

resident was provided with fluids using two different items and not the assistive device.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 23, 2015, as a Compliance Order (CO) in a Critical Incident System Inspection #2015_271532_0020, and on June 7, 2016, as a Voluntary Plan of Correction (VPC) in a Critical Incident System Inspection #2016_217137_0014. [s. 73. (1) 9.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

Review of the plan of care for an identified resident showed that they needed a specific level of assistance to for eating.

Observations completed during a specific meal showed that staff served food to the resident prior to staff being available to provide assistance with eating.

Observations during another meal found food was placed on the table for this resident prior to the resident arriving in the dining room. The staff member was observed to provide assistance to this resident fourteen minutes after the resident's food had been set out.

During interviews with staff they reported that this resident required a specific level of assistance with eating.

The Assistant Coordinator St Mary's (SM) stated that residents who required assistance with eating should not be served until staff were available to provide assistance.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 26, 2014, as a VPC in a Follow-up Inspection #2014_182128_0001. [s. 73. (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 residents are provided with assistive devices to safely eat and drink as comfortable and independently as possible and to ensure that residents who require assistance with eating and drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Dietitian (or dietitians) who was a member of staff of the home was on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During interviews it was reported that the home had one Registered Dietitian (RD) who worked full time and one RD who worked one day per week. The RD stated that they were behind on assessments and estimated this was by approximately one to two weeks. The RD stated that they prioritize assessments of residents and stated that they usually completed the admission and quarterly assessments and then try to complete the assessments for those with weight loss.

During an interview the Director of Food and Nutritional Service (DFNS) and Director of Mount Hope stated that they had one and a half Full Time Equivalent (FTE) at the home and they believed they required an additional 0.01 FTE. The home had 394 beds which would require the licensee to have a RD onsite to carry out clinical and nutrition care duties for 197 hours per month.

Documentation of the combined RD hours worked for September 2016 was 169 hours; October 2016 was 132.5 hours; November was 180 hours and December was 130 hours.

During an interview Director of Food and Nutritional Service (DFNS) stated that they filled the RD based on the number of quarterly and annual assessments. The Director of Mount Hope and DFNS acknowledged they had not back filled for the RD's paid time off. They stated based on calculations they did not have sufficient RD hours onsite.

The licensee has failed to ensure that a Registered Dietitian (or dietitians) who was a member of staff of the home was on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #15: 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 a medication cart, which was secure and locked.

On a specific date and time, Inspector #615, was walking in a specific area of the home heading to the dining room. At the same time a registered nursing staff member was walking away from the medication cart heading to the nurse's station. Inspector #615 approached the medication cart that was at the dining room door in the hallway and was observed to be unlocked. Many residents and employees were walking by the cart at that time.

This staff member acknowledged to Inspector #615 that the medication cart was left unattended and unlocked. This staff member said the home's expectations for medication carts was that they were locked when left unattended.

During an interview with Coordinator MV they shared that the home expectations for medication carts was that it was to be locked when they were unattended.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 13, 2014 in a Resident Quality Inspection #2014_182128_0009 as a VPC, on January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, and June 7, 2016, in a Critical Incident Inspection #2016_217137_0014 as a VPC. [s. 129. (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 drugs are stored in a medication cart that is secure and locked, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

a) Observations by Inspector #523 on a specified date found unlabelled personal hygiene items including hair brushes, razors, deodorant in the common spa rooms.

Observations by Inspector #523 on a specified date also found staff members provide care to multiple residents without cleansing hands or changing gloves between residents.

In an interview an identified staff member they stated that the expectation was that they were to change gloves after care was provided.

During an interview with Infection prevention and Control (IPAC) Practitioners they stated that the expectation was that staff would ensure that resident's personal hygiene items were labelled and the expectation related to staff wearing gloves was that they wash their hands before using gloves, they use their gloves for the task and they dispose of the gloves after the individual task. (659)

b) Observations on a specific date found a staff member walking out of a resident room having gloves on both hands and then went into another resident room

wearing the same gloves, and headed to the washroom.

During an interview this staff member confirmed that they were in the resident room and then went to another room where they assisted resident to the bathroom. This staff member said that the expectation was that they don't have to change the gloves between residents or rooms if they did not touch the resident.

During an interview with another staff member in the home they said it was the home's expectation was to change gloves and wash hands between residents. They shared that staff can't touch resident's bed and sheets and then use the same gloves with other residents, this was not a good infection prevention and control practice.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents cannot be opened more than 15 centimeters (cm).

On December 5, 2016, a tour of the home found that windows in the following tub rooms opened greater than 15 centimeters:
- Tub room # Y409 window opened 46 centimeters (cm).
- Tub room # Z315 had two windows each opened 52 cm.
- Tub room # Z215 had two windows each opened 52 cm.
- Tub room on first floor window opened 52 cm.

On December 5, 2016, the Coordinator SM said that showers were based on an individual basis and if a cognitively and physically capable resident requested to have a shower by themselves the home would allow them to do so. Coordinator SM acknowledged that it was possible for a resident to be present in the tub room by themselves.

On December 5, 2016, a tour of the above tub rooms with Director of Mount Hope and they said that windows opened more than 15 centimeters.

On December 5, 2016, Director of Mount Hope said that they were putting in an urgent request to fix the windows and ensure that they don't open more than 15 cm. In the meantime, staff were to monitor residents in the tub room.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 16.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect the organized program required under sections 10 of the Act (Recreation and Social Activities Program): There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On January 3, 2017, in an interview the Recreational and Social Activity Team Lead (RSATL) said that they were new to the home and just started working on a new model and approach to therapeutic services, they said that the home was currently using the "Therapeutic Recreation Program Planning Model" or "Leisure Well-being Model", the premise of the model was to focus on resident's ability. RSATL was not able to provide procedures as to how to assess the cognitively impaired residents or residents that did not speak English. They said that they were working with this planning model and they would be working on other strategies. They also acknowledged that the program was not evaluated.

On January 3, 2017, RSATL said that the current program did not have written description that include goals, objectives, relevant policies and procedures, methods to monitor outcomes and protocols for referral of resident to specialized resources where required, and that the program was not evaluated.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 30.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received individualized personal care, including hygiene and grooming on a daily basis.

The clinical record for an identified resident showed that this resident was dependent on staff for assistance with personal grooming care.

The plan of care for this resident indicated the resident required assistance for personal grooming care.

The Point of Care (POC) response history for a specific time period for this type of personal grooming care showed that it had been completed two to three times per day in a 30 day time period.

Observations during the inspection found this resident had not received this personal grooming care.

During interviews, this resident reported a preference to have this personal grooming care provided.

During interview with identified staff members they stated that the resident received that personal grooming care on their bath day, twice a week if needed.

Coordinator St. Mary's (SM) stated that if the resident required daily grooming care then this should have been completed. The Coordinator SM stated that the expectation was that staff should follow the plan of care.

The severity was determined to be a level one as there was minimal risk of harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 32.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident received assistance to insert dentures prior to meals and at any time when required by the resident's plan of care.

Record review indicated that this resident was reliant on total staff assistance for hygiene and oral care.

This Resident plan of care documented that staff were to ensure the resident's dentures were in their mouth and cleaned before meals; removed and soak dentures at night.

Observations on specific days found that the resident was not observed to be wearing their dentures.

During an interview with a family member with this identified resident they expressed concern that the resident did not have their dentures in.

During an interview the Coordinator SM stated the expectation was that staff follow the plan of care.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 34. (2)]

WN #21: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted prior to a volunteer being accepted.

Orientation documentation for an identified volunteer showed the volunteer did not have a criminal reference check six months before being accepted by the licensee.

Record review indicated that the Vulnerable Sector check was completed by London Police Service which was not completed six months before being accepted to volunteer.

During an interview with the Volunteer Coordinator they acknowledged that the volunteer did not have a criminal reference check six months before being accepted by the licensee.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 75. (2)]

WN #22: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors.

During Stage One room observation of a Resident Quality Inspection (RQI), strong urine odors were detected in a specific resident room.

On specific dates a very strong odor of incontinence was noted by Inspector #634.

During an interview with a resident who lived in that room they said that they noticed a mild smell in the room.

Interview was completed with an identified staff member they said that there were no procedure in place related to lingering offensive odors of resident rooms and that when rooms had a lingering offensive odor, they were cleaned more frequently and with a stronger cleaning product but this was not identified in a procedure.

During an interview with another identified staff member they said that this resident room had a strong odor present.

During an interview the Director of Mount Hope and the Coordinator MV they said that the home was not equipped with procedures to address lingering offensive odors.

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 87. (2) (d)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On December 09, 2016, during a tour of the basement, it was shared by an identified staff member that they worked for shipping and receiving department. They described that they received the government supplies as part of their duty and delivered the government supplies to the storage room. They shared that they were also responsible for delivering and stocking up the medication room with medical supplies on the units. They had access to all areas/rooms where drugs were stored through the access card to ensure all of the units were topped up with medical supplies.

During an interview this was discussed with a Pharmacist who worked in the home and they acknowledged that this staff member was not to have access to the medication rooms as they were not part of the team who dispense, prescribe or administer drugs in the home, and they were not the Administrator as stated in the Regulations.

In an interview an identified staff member shared that they still receive the government supplies as part of their duty and delivered the government supplies to the storage room where the stock medications were kept, the area where drug was stored was not restricted to persons who may dispense, prescribe or administer drugs in the home.

The severity of this area of non-compliance was minimal harm. The scope was determined to be isolated as it involved this one staff. There was a history of previous unrelated non-compliance. [s. 130. 2.]

WN #24: 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 home's drug destruction and disposal policy included that controlled substances that were to be destroyed and disposed were stored in a double-locked storage area within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurs.

On January 9, 2017, the policy "Destruction and Storage of Surplus, Expired, and Or Discontinued Medications Original" Effective Date: December 1997, Revised Date September 2016, stated the following: "Narcotics and controlled drugs (NCDs) for destruction must be kept in the locked narcotic bin in the locked medication cart until the pharmacist visits the unit; NCDs for destruction must be clearly separated from NCDs for regular administration by placing the NCDs for destruction in a clear zip-lock bag."

On January 9, 2017, the Pharmacist acknowledged that controlled substances available for administration had been kept together in the locked narcotic bin in the medication cart with the other controlled substances until time for destruction. The drugs for destruction were not separated from drugs that were available for administration to a resident.

On January 9, 2017, observation for two specific areas in the home found that both had controlled substances for destruction stored inside the locked narcotic bin with the controlled substances for administration.

On January 9, 2017, the Pharmacist acknowledged that there were separate bins for destruction that were available on each unit for the Narcotics and controlled drugs, however, the boxes were not in use as there was no education provided to staff at the time of the inspection.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC. [s. 136. (2) 2.]

Issued on this 16 day of June 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMIE GIBBS-WARD (630) - (A1)

Inspection No. / No de l'inspection : 2016_457630_0045 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 031087-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 16, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_217137_0014, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 will protect all residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee will implement their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016. Education and training shall be provided to all staff including the home's policy to promote zero tolerance of abuse. The licensee will monitor, evaluate and adapt their compliance plan to ensure all residents will be protected from abuse and neglect.

Grounds / Motifs :

1. The licensee has failed to ensure all residents were protected from abuse by anyone.

A Critical Incident (CI) System Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which identified that a potential resident to resident abuse had occurred.

The clinical records for two identified resident showed that potentially non-consensual touching and behaviours had occurred between two residents.

The clinical record for one of the identified residents showed a history of behaviours and potential abuse of other residents prior to the reported CI. This record also showed no documentation of an assessment related to behaviours for this identified resident was completed by the physician until after the CI. The record showed no referrals had been made or assessments completed by the Behavioural Supports Ontario (BSO) program in the home prior to the CI. There was no involvement of external resources regarding the assessment of behaviours until after the CI. The plan of care for this identified resident did not identify triggers for potentially harmful interactions with other residents related to behaviours or ways to minimize the potential for touching of other residents.

During an interview with an identified staff member it was reported that prior to the CI they were not aware of any incidents of this identified resident having inappropriate behaviours towards other residents or aware of potential triggers for the behaviours.

During an interview with another identified staff member it was reported that there had been incidents of this identified resident touching other residents prior to the CI. This staff member reported they had received training on the prevention of abuse and neglect. This staff member said that previous incidents of touching between this identified resident and other residents seemed to have been consensual but said that it was difficult to determine. This staff member said they could not recall specific training that they had received and they needed further education in the home.

During an interview with the Coordinator Marian Villa (MV) and the Coordinator Assistant MV it was reported that the home did not have a policy to direct staff regarding behaviours and a specific assessment related to this behaviour as this would be covered by the home's policy on the prevention of abuse and the Resident's Bill of Rights. They reported this identified resident had a history of inappropriate behaviours with other residents prior to the reported CI. The Coordinator MV said that there should have been assessments completed and more interventions put in place to help minimize the risk for abuse.

The severity was determined to be a level three as there was actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 26, 2016, in

Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO). (630)

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

Aug 31, 2017(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, is implemented. The licensee shall ensure that all staff are educated on the home's policy including reporting mechanisms and that there is a monitoring process in place to ensure that the home's abuse policy is implemented.

The education and training provided to all staff must include re-education regarding sexual abuse. This education must address consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities.

Grounds / Motifs :

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, which was in place in the home until September 27, 2016, titled "Abuse and Neglect of Residents: Zero Tolerance" and "Original Effective Date August 2001; Revised Date July 2014" included the following procedures:
6. "When an incident of alleged, witnessed or suspected abuse or neglect of a resident occurs it is mandatory that the person who becomes aware of the abuse report the incident immediately to the RN; in the evenings, at night or on weekends the RN informs the Clinical-on-call; the RN will call the Coordinator so they can inform the Ministry."
9. "The Coordinator of Resident Care will fully investigate any alleged, witnessed or suspected abuse immediately. This may be done by interviewing all relevant parties, examining documentation or other evidence, or by directing a designate to do so."
10. "When possible the Coordinator/Clinical-on-Call or their designate will ask staff or others who have witnessed or have knowledge of the suspected abuse or neglect to provide individual statements, independently of each other, describing the detail of what occurred."

a) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which reported an alleged incident of staff to resident abuse.

The clinical record for an identified resident showed their family member had reported a concern to a staff member regarding an alleged abuse incident.

During an interview the Assistant Coordinator Marian Villa (MV) said that the staff working on the date of the CI had not notified the Clinical Registered Nurse (RN) or called the manager on call immediately after having been made aware of an alleged incident of staff to resident abuse. Assistant Coordinator MV said that the investigation into the alleged abuse was not started immediately. The Assistant Coordinator MV said they had informal conversations with the staff working on that floor regarding the family's concerns but they did not ask staff if they had witnessed any abuse or document interviews with staff regarding the alleged incident. The Assistant Coordinator MV acknowledged that the home's policy to promote zero tolerance of abuse as it related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse was not complied with. Assistant Coordinator MV said it was the expectation in the home that the policy would be followed and all staff in the home had recently be retrained on a revised version of the policy to promote zero tolerance of abuse. (630)

b) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which reported an alleged incident of resident to resident abuse. This report stated that a previous incident had occurred between these two identified residents.

The clinical record for an identified resident showed previous incidents of touching between these two residents prior to the CI which had been documented in the internal incident reports.

During an interview with the Coordinator MV they said that they thought there had been no reported incidents of alleged abuse between two residents prior to the CI. Coordinator MV said that the home's internal incidents reports were not reviewed immediately by the management staff and this was not how the staff in the home were to immediately notify the management of alleged abuse. The Coordinator MV said the expectation in the home was that any type of touching between residents would be reported to the Coordinators as potential abuse and investigated as per the

policy. Coordinator MV acknowledged that there had been past incidents of touching and behaviours between residents identified in the internal incident reports and progress notes that had not been dealt with as per the policy. Coordinator MV acknowledged that the staff had not reported the potential abuse to management as per the home's policy and there had not been immediate investigations completed.

During an interview the Director of Mount Hope said that the only policy related to touching was encompassed within the prevention of abuse policy and there was no other policy that it would fall under to direct staff regarding the assessment of touching and behaviours of residents. The Director of Mount Hope said that they thought they did not have a specific way to assess residents related to these behaviours but they would consider the Cognitive Performance Scale (CPS). The Director of Mount Hope said consensual or non-consensual touching would be dealt with in the same way in the home and would be considered possible abuse and should be dealt with as per the policy on prevention of abuse and neglect. (630)

c) The clinical record review for an identified resident showed a history of behaviours towards other residents. This clinical record showed an incident of potentially non-consensual behaviours and touching that occurred between this identified resident another resident.

During an interview with the Coordinator MV they said that they were not aware of any incident of alleged abuse between this identified resident and other residents in the home. The Coordinator MV checked the internal incident reporting system and noted that there was no record of the incident. The Coordinator MV said that the staff did not report the incident to the charge RN and therefore the charge RN and the management had not been made aware of the incident. The Coordinator MV acknowledged that the home's policy called "Abuse and Neglect of Residents" was not complied with related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse. (523)

d) A Critical Incident (CI) System Report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) which was identified as an "incident that caused an injury to a resident for which the resident was taken to hospital" but did not identify alleged "staff to resident abuse." This report stated that the identified resident had told staff that a staff member had hurt them.

The clinical record for an identified resident showed that at the time of the CI the

resident had reported to staff that they thought that a staff member had hurt them.

During an interview with the Coordinator MV it was acknowledged that the policy for prevention of abuse and neglect was not followed for this CI related to the alleged abuse as they had not fully investigated and did not have documented written statements from the staff involved.

Based on the review of these critical incident reports, interviews with staff and management in the home and review of the clinical records including the home's internal incident reporting system the licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, that was in place at the time of the incidents, was complied with related to staff immediately reporting alleged abuse to the management in the home and immediate investigation of any alleged abuse.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 7, 2016, in a Complaint Inspection #2016_260521_0002 as a VPC, on May 26, 2016, in Critical Incident Inspection #2016_226192_0022 as a Compliance Order (CO) and a Director's Referral (DR), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC. (630)

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

Aug 31, 2017(A1)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee shall ensure that all elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

The licensee shall ensure that all elevators leading to the basement are equipped to restrict resident access to areas that are not to be accessed by residents.

Grounds / Motifs :

1. The licensee of a long-term care home has failed to ensure that any elevators in the home were equipped to restrict resident access to areas that were not to be accessed by residents.

Multiple observations over the course of the Resident Quality Inspection found that the elevator leading to the basement of the home enabled residents to access multiple rooms and areas that were not to be accessed by residents.

On December 9, 2016, at 1237 hours it was noted that there was a tunnel that connected both St. Mary's and Marian Villa home areas to the St. Joseph's Hospital. The service elevator in alcove Z028 on Marian Villa side was taken by Inspectors #523, #532 and #659 and it was noted that the elevators were opening up to the resident home areas. The Inspectors took the service elevator from the basement to the Marian Villa Third Floor and noted it opened onto the resident home area. The Inspectors then took the elevator back to the main floor and the rear door of the elevator opened to the main kitchen.

On December 9, 2016, tour of the basement completed by Inspectors #523, #532 and #659 found the following:
- A stairwell leading to an unlocked door which exited to the outside and this was

labelled as "Emergency Exit".
- "Ladies Locker Room", "Men's Locker Room" and "Bathroom" were unlocked.
- An unlocked door leading to a stairwell which led to an additional stairwell.
- "Mechanical Room" door was unlocked which led to the "Boiler Room" and there was an unlocked door inside of this room documented as "4, 160 volts".
- An unlocked door "B-002" which was documented as "Authorized Personnel Only"
- An unlocked door "VB-46" to food services area.
- An unlocked door "VB-24" "Mail Room" with a signed which stated "Please do not lock".
- An eye wash station was located in hall with "Virex", "Crew" bathroom cleaner and scale remover, "Glance HC" glass and multi surface cleaner and "Stride" fragrance free SC neutral cleaner, broken glass and florescent lights were sitting in an open bin.
- The automatic doors leading to the loading dock were unlocked.
- An unlocked door "VB18" receiving doors and was observed to be open.
- An unlocked door "WB05" "Laundry Room" with laundry detergent.
- A family member was observed pushing a resident in a wheelchair through the basement hall.

On December 9, 2016, at 1247 hours an identified staff member told the Inspectors that often people got lost coming out of parking garage and ended up in the tunnel. This identified staff member said that staff, visitors and clients took the basement tunnel. An identified staff member said that there were residents who would use the tunnel. This staff member said that the door to the food service area was usually open until 1430 hours.

On December 9, 2016, an identified staff member said the doors should have been locked and acknowledged that room "B023" was unlocked at the time of the interview.

On December 9, 2016, at 1345 hours the Director of Mount Hope accompanied Inspectors #523, #532 and #659 on a tour of the basement. The Director of Mount Hope said that residents did not usually access the basement but there were residents who did use the tunnel from the basement. They said they were aware that residents accessed the tunnel. The Director of Mount Hope acknowledged the immediate risk for resident safety.

On December 9, 2016, at 1500 hours, the Director of Mount Hope and the Facility

Coordinator (FC), contacted the Inspectors and shared that they were working on a plan to address the safety concerns with the doors. The FC said that the plan was to put a card reader on the double access door in the Marian Villa side of the basement. The FC said that on December 12, 2016, they would make a "rush order". The FC said they were also planning to put an access card reader on the service elevator and they were going to ensure all doors were closed and no residents would be able to access these areas. Director #100 said that a communication was going out to staff to reiterate the importance of completing the hourly checks to ensure residents were accounted for.

On December 12, 2016, at 1230 hours, Inspector #630, #659 and #532, noticed that room "B002" marked as "Authorized Personnel Only" was open and not locked.

On December 13, 2016, at 1200 hours Inspector #532 took elevator from the Marian Villa side down to the basement. It was observed that the main door to enter the basement was open, and the doors leading to the "Male Locker Room" and "Female Locker Rooms" were unlocked, the "Emergency Exit" door leading outside was unlocked and the "Shipping and Receiving" doors were unlocked. The Inspector also observed residents and families taking the basement tunnel to go to St Joseph's hospital.

On December 15, 2016, at 1200 hours Inspectors #532, #630 and #659 took elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked, the "Mechanical Room" "B-012" was unlocked, and "Shipping and Receiving" doors were unlocked.

On December 15, 2016, the Director of Mount Hope was asked about the doors in the tunnel and they stated that they had not spoken with the Director of Facility (DOF) since December 12, 2016.

December 20, 2016, at approximately 1200 hours, Inspector # 659 and #630 observed that the "Emergency Exit" door leading to the outside was not locked.

On December 21, 2016, at 1200 hours, Inspectors #659, #630, #634 and #523 took elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked, the "Male Locker Room" and "Female Locker Rooms" were unlocked, and the "Shipping and Receiving" doors were unlocked.

On December 21, 2016, at 1529 hours, Inspector #523 observed a resident walking alone with their walker in the tunnel near the shipping doors.

On December 22, 2016, at 1330 hours Inspectors #659, #532, #630 and #634 took the elevator from the Marian Villa side down to the basement. It was observed that the "Emergency Exit" door leading outside was unlocked and the "Male Locker Room" and "Female Locker Rooms" were unlocked.

On December 22, 2016, at 1435 hours the Director of Mount Hope, the Facility Coordinator (FC) and the Director of Facility (DOF) accompanied Inspectors #523 and #532 on a tour of the basement. Observed the door by the elevator Z0-E04 north door was locked and staff were using the key to get in and out of the door. The DOF acknowledged that the locking of the door had been implemented just prior to the tour. The DOF said that the locking of the door was part of an immediate plan to have the north door locked. Inspector #532 identified to the management that the door by the elevator leading to the basement was found to be unlocked on multiple occasions during the inspection. The DOF said that they wanted to implement an action plan right away, however, it took time to get the parts for the lock. The DOF said from that point on the basement would be under complete lock down as they had locked all the doors and there was no access to the basement.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. (532)

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

Jun 30, 2017

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_217137_0014, CO #002;

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 shall ensure that the home's resident-staff communication and response system can only be cancelled at the point of activation.

The licensee shall ensure that the resident-staff communication and response system which signals at the nursing station can only be deactivated from the point of activation not at the nursing station.

Grounds / Motifs :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that allowed calls to be cancelled only at the point of activation.

On September 29, 2016, inspection number 2016_217137_0014, CO #002, the

licensee was ordered to take action to achieve compliance by ensuring the home was equipped with a resident-staff communication and response system that could not be cancelled at the nurse's station or at other locations other than the point of activation. This order was to be complied with by November 10, 2016.

Observations by Inspector #523 on Marian Villa Second Floor found the resident-staff communication and response system signalling at the nursing station and an identified staff member was at the nursing station at the time. Inspector #523 asked the staff member if staff were able to cancel the signal from the nursing station they said "no". Inspector #523 observed holes in the glass cover over the resident-staff communication and response system. Inspector #523 went to an identified room and activated the response system and then Inspector #523 was able to deactivate the signal using a pen through the hole while in the presence of the staff member. The staff member then said that staff were able to deactivate the signal at the nursing station but said that they did not think that staff would do that.

During an interview the Director of Mount Hope told Inspector #523 that it was possible for staff to deactivate resident-staff communication and response signals from the nursing station not just at the point of activation.

Review of Work Order 2007244305 indicated "change all pexi glass covers on all levels of Marian Villa" with date completed December 7, 2016.

During an interview the Director of Mount Hope told Inspector #630 that they changed the type of cover that was over the resident-staff communication and response system on December 7, 2016, as the previous cover did not ensure that staff could not deactivate the system from the nursing station.

The severity was determined to be a level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 5, 2016, in a Resident Quality Inspection #2016_254610_0001, as a Voluntary Plan of Correction (VPC), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO)

The severity was determined to be a level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. There was a compliance history of this legislation being issued in the home on January 5, 2016,

in a Resident Quality Inspection #2016_254610_0001, as a Voluntary Plan of Correction (VPC), and on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO). (630)

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

Jun 30, 2017

Order # /
Ordre no : 005

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 shall ensure the resident-staff communication and response system is properly calibrated so that the level of sound is audible to staff. The licensee shall ensure that the resident-staff communication and response system in all home areas in Marian Villa is audible to all staff providing direct care to residents at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Inspector #630 observed that the call signalling for a room in Marian Villa was audible only from the resident-staff communication and response system intercom at the nursing station.

During an interview with a staff member it was reported to Inspector #630 that the only place the signal was audible was from the resident-staff communication and response system at the nursing desk. This staff member said it should have been signalling from the black phone down the hallway but it was not audible from that phone at that time. This staff member said that staff could adjust the volume on the phones.

Inspector #630 and #523 observed on Marian Villa Third and Fourth Floors that the black phone outside resident rooms, which were the auditory part of the resident-staff communication and response system, had the volume turned down or off. Inspectors #630 and #523 were able to turn the volume off and on using this black phone. It was also observed that not all hallways had black phones.

During an interview with another staff member it was reported that when a resident had activated a call bell the staff would hear the signals on the black phones in the hallways and from the main panel at the desk. This staff member said that there were times when they could not hear the call bell if they were in another room especially the end rooms. This staff member said that sometimes the night staff would turn the volume down or turn off the ringer. This staff member also said the resident-staff communication and response system was hard to hear when they were in rooms providing care. Inspector #630 and #523 went into a specified resident room in Marian Villa with this staff member and the call bell was activated and the system

could not be heard.

During an interview with another staff member it was reported to Inspector #630 and #523 that staff could turn off the volume on the black phones and then staff would only be able to hear the signals at the desk. This staff member also said that residents would play with the phones at times and turned down the volume. This staff member said there were rooms that staff could not hear the resident-staff communication and response system and it needed to be louder.

An identified staff member observed with Inspectors #630 and #523 that the call bell for a specific resident room in Marian Villa was signalling and was not heard in the room. This staff member pulled the cord out and could not hear the signal. This staff member said the staff did not carry pagers and that there was no black phone in the hallway in that area. This staff member said they looked for the flashing light on the wall to identify that a resident was signalling for assistance. This staff member said that they also relied on the registered staff at the desk to notify them of a signal if they did not see it.

During an interview the Director of Facilities (DOF) told Inspector #630 that it was their understanding that the black phones were not an essential part of the resident-staff communication and response system. The DOF said that staff could hear the signals from the intercom at the desk from anywhere on the floor. The DOF said they tested the resident-staff communication and response system to ensure the signals were auditory when they put the plastic covers over the intercom at the desk. The DOF said they tested all floors and they determined it could be heard in all areas.

Inspectors #532, #523 and #630 with the Director of Mount Hope, the Facility Coordinator (FC) and the DOF toured Marian Villa Third Floor and observed the phone in the hallway beside an identified resident room. DOF acknowledged the phone was able to have the volume turned off. Inspector #523 activated the resident-staff communication and response system in a resident room and the Director and the FC acknowledge that the call bell was not audible from the nursing station and the phone was not making any sound. The DOF said the home needed to come up with a plan to ensure that staff could hear the call system in the hallway.

Inspectors #532, #523 and #630 toured Marian Villa Fourth Floor with FC. Standing in hallway outside a specified resident room there was a resident signalling for assistance and it was not audible in this hallway. The FC indicated that they

identified that the resident-staff communication and response system was not auditory in all areas not just due to the black phones not being able to be heard but also because the volume of the intercom at the nursing station was not high enough. The FC said they needed to look at improving their call response system.

The severity was determined to be a level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. (630)

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

Jun 30, 2017

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

3. Resident monitoring and internal reporting protocols.

4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee shall ensure that the Responsive Behaviours program in the home is developed and implemented. This will include written approaches to care, screening protocols, assessments, reassessments and identification of behavioural triggers for an identified resident and all residents in the home with responsive behaviours.

The licensee shall ensure there is a process in place for monitoring the implementation of the actions taken, including who is responsible.

Grounds / Motifs :

1. The licensee has failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Review of the clinical record for an identified resident showed they had a history of responsive behaviours. The clinical record did not include assessment of resident's history of behaviours or potential triggers, no written screening protocols, assessments, reassessments or the identification of behavioural triggers that had been completed. Further review of the Patient Safety Reporting System (PSRS) forms completed for responsive behaviours for this resident found that not all

incidents described in the progress notes had a PSRS completed.

During an interview with an identified staff member it was reported that at the time of the inspection the home was working to improve the Behavioural Supports Ontario (BSO) program in the home. This staff member said any assessments that had been completed for this identified resident would have been in the hard copy of the chart. This staff member said that staff on the floors used their discretion as to when to refer to the BSO in the home. They also said the BSO team then would use their discretion as to when to refer to external specialized resources but there was not written protocols within the home regarding these referrals.

Review of the home's policy titled "Resident Aggression and Responsive Behaviours" and "Revised Date April 2016" indicated the following:
- "All incidents involving responsive behaviours are documented in the residents chart as well as in the on-line PSRS." The policy did not identify who was responsible for monitoring the PSRS sheets.
- "Behavioural flow sheets used to track behaviours over time and according to time of day and event may be used to identify patterns of behaviour and the triggering events for behaviour." The policy did not provide further guidance as to which staff were to use the flow sheets, when to use the flow sheets, and which flow sheets to use or other screening tools or assessment tools that were to be used regarding responsive behaviours.

On December 20, 2016, Coordinator MV told Inspectors #630 and #523 that they were working with external resources to revise and improve the program in the home to manage responsive behaviours which included working to improve the BSO program. The Coordinator MV acknowledged the program in place at the time of this inspection did not contain written protocols for screening residents, assessments including the assessment tools that were to be used, protocols for referring to the internal BSO or external services. The Coordinator MV said that the program needed improvement in terms of the written strategies in the home for responsive behaviours.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016, in Complaint Inspection #2016_262523_0025 as a Compliance Order. (630)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Jun 30, 2017

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that for an identified resident and for each resident demonstrating responsive behaviours actions are taken to respond to those needs of the resident, including assessments, reassessments and interventions and that the resident's responses to the interventions are documented.

The licensee shall ensure there is a process in place for monitoring the implementation of the actions taken, including who is responsible.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Review of the clinical record for another identified resident showed that this resident had a history of responsive behaviours.

During interview with multiple staff over the course of the inspection it was reported that this identified resident had been inappropriate with staff and had responsive behaviours.

During an interview with a staff member who worked with the BSO program it was reported that they did not receive any referrals for the resident related to any responsive behaviours. This staff member said that these behaviours expressed by the resident required a referral to the BSO team for assessment and determining interventions.

During an interview with Coordinator MV it was reported that the resident should have been referred to BSO team given that responsive behaviours continued to occur despite the initial interventions. Coordinator MV said that they would discuss it with the team to ensure that if responsive behaviours continue and initial interventions were not successful that they need to refer to BSO.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016, in Complaint Inspection #2016_262523_0025 as a Compliance Order. (523)

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

Jun 30, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Linked to Existing Order / Lien vers ordre existant: 2016_217137_0014, CO #003;

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 shall ensure that all hazardous substances in the basement of the home and in all areas of the home are kept inaccessible to residents at all times.

The licensee shall ensure that all doors leading to the basement are equipped to restrict resident access to areas that are not to be accessed by residents due to the presence of hazardous substances .

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, is implemented. The licensee will monitor, evaluate and adapt their compliance plan to ensure that hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On September 29, 2016, inspection number 2016_217137_0014, CO #003, the licensee was ordered to take action to achieve compliance by ensuring that all hazardous substances at the home were kept inaccessible to residents at all times.

On December 9, 2016, Inspectors #523, #532 and #659 observed that the basement in Marian Villa was accessible by residents through the service elevator. The inspectors also observed an unlocked housekeeping cart in the basement with unsecured chemicals. The inspectors observed the following unlocked areas which contained hazardous substances:
- The "Mechanical Room" door "B-012" had spray paint cans.
- The "Laundry Room" in basement was unlocked with chemical detergent named "Clax Assist".
- The "Shipping and Receiving Room" unlocked with Virox, "Crew" bathroom cleaner and scale remover.
- The basement hallway unlocked with "Glance HC" glass and multi-surface cleaner, "Stride" fragrance free, "SC Neutral Cleaner".

On December 9, 2016, the Director of Mount Hope toured the basement with Inspectors #523, #532 and #659 and acknowledged the basement was accessible to residents and hazardous substances at the home were accessible to residents.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order. (630)

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

Jun 30, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure for an identified resident and for all residents with identified risks related to nutrition and hydration there is a system developed and implemented to monitor and evaluate their food and fluid intake, in consultation with a Registered Dietitian who is a member of the staff of the home.

Grounds / Motifs :

(A1)

1. 1. The licensee has failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

An identified resident was listed as being at high nutritional risk by the Registered Dietitian (RD).

Review of the nutritional intake and snacks as documented on Point Click Care (PCC) showed this resident refused multiple meals and snacks during a specific time period.

The clinical record also showed a significant weight loss occurred in a specified time period and the resident was below their goal weight range that had been established by the home's RD. There was no referral to the RD related to the self/adaptive aids required/limited assistance with feeding.

During an interview the Director of Mount Hope and the Director of Food and Nutritional Service (DFNS) initially stated that they were not familiar with who was responsible for monitoring the fluids and nutrition intake at the end of the shift or day to ensure residents met the minimum target intake requirements. Later the Director of Mount Hope stated that monitoring of the resident's nutritional intake would be done by the Registered Dietitian (RD) as part of the quarterly assessments. At other times during the quarter the Personal Care Provider (PCP) or nurse should be monitoring the resident's intake and they could put a referral into the RD if needed.

During an interview with the RD they said they did not recall having been made aware of this resident's refusal of food as it was up to the staff in the area to notify the RD of any changes.

During an interview with the Dietary Technician (DT) they stated that the night nurse created alerts to the RD for low fluid intake and they said they may on occasion do the same for nutritional intake but they did not think that the nutritional intake was monitored.

The home's policy titled "Nutrition Assessment, Reassessment, Care Planning, Documentation, Follow up" with "Revised August 2015", documented that if nursing staff would like the resident assessed from a nutrition point of view at any time during their stay, or would like to initiate diet changes, etc. a consult to the RD/DT could be

communicated at any time. This policy did not include direction regarding a referral to the Registered Dietitian's in response to a resident's altered nutritional intake. The licensee's policy related to nutrition and hydration management addressed monitoring related to fluid intake, but not related to nutritional intake.

During an interview with the Coordinator Food and Nutrition Service they stated that there was no procedure for monitoring the nutritional intake of residents.

The licensee failed to ensure that there was a system to monitor and evaluate the food intake of residents with identified risk related to nutrition and hydration.

The severity was determined to be a two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection since the home did not have a system in place to monitor and evaluate food intake of all residents with identified risk related to nutrition. The home does not have a history of non-compliance in this subsection of the legislation. [s. 68. (2) (d)] (659)

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

Jun 30, 2017

Order # /
Ordre no : 010

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order / Ordre :

The licensee will ensure that the care set out in the plan of care is provided to the resident as specified in the plan, for all residents and specifically:
a) That an identified resident is provided the care set out in the plan of care for recreation and social activities and for any Personal Assistive Services Device (PASD) with restraining qualities;
b) That an identified resident is provided the care set out in the plan of care for denture care.

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, is implemented.

The licensee shall ensure there is a system in place to monitor that the care set out in the plan of care is being provided to residents as specified in the plan including who will be responsible for monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that care was provided as specified in the plan of care.

Clinical record review for an identified resident showed care plan interventions that included use of a specific device for positioning an safety.

A clinical record review stated that this resident was to have this device checked at specific time frames. A further review of the report for a specific time frame found that eight per cent of the tasks were not signed.

In an interview Coordinator MV they said that the staff were expected to ensure care in the plan of care was delivered and checks were completed and signed for. Coordinator MV acknowledged that the checks were not signed for and could not confirm if the tasks/care from the plan of care were completed. (523)

2. During a clinical record and plan of care review with an identified staff member they stated that the goal was to have an identified resident engaged in a minimum of four activities per week.

A review of the monthly report showed the following activities completed as follows:
September 2016: nine activities per month.
October 2016: three activities per month.
November 2016: four activities per month.
December 2016: two activities per month.

This staff member informed Inspector #523 that the plan of care and required goals were not being followed and the care set out in the plan was not being provided.

Coordinator of Recreational and Social Activity Programs (RSAP) said in an interview that the expectation was that the resident would attend activities as indicated in the care plan. They said if the resident refused or was busy then staff were to document this. The Coordinator RSAP identified that they already had an action plan in place to address this concern. (523)

3. Review of the clinical record for an identified resident showed they required a specific level of assistance with personal care.

The resident's plan of care documented that staff were to ensure that the resident had a specific type of personal care provided after meals and at night.

Review of documentation for a specific time frame showed documentation for this personal care was completed twice a day.

Inspector #659 observed that this resident did not receive the personal care listed in the plan of care during a specific time period.

During interviews with this resident they stated that staff assisted with this personal care once a day.

During interview with staff they reported they provided the care twice daily.

During an interview with another staff member they stated that it was too much to provide the personal care as specified in the plan of care.

The Coordinator SM stated that the expectation was that staff would follow the plan of care.

4. Observations of an identified resident during a specific time period showed they were using a specific device and the device appeared to be applied incorrectly.

Observations made on with an identified staff member showed that this device was applied incorrectly. This staff member said this was unacceptable as it was a potential risk to the resident.

The plan of care in place for this resident at the time of the inspection showed that this resident had a specific device. This also stated that staff were to monitor routinely for safe and proper positioning and remove.

An identified staff member told Inspector #523 that they did routine checks at certain intervals on residents and ensured that devices were applied correctly. This staff member said that they went to check on the device. This staff member was observed placing this specific device back onto the resident and it continued to be applied incorrectly.

Assistant Coordinator MV checked the specific device and said that it was not applied correctly. They were then observed to adjust the device.

In an interview with the Occupation Therapist (OT) they said that the device should be applied correctly and that this was an inappropriate application of the device.

During an interview Coordinator MV they said that they were made aware that the devices were applied incorrectly. They said that the home's expectation was that when staff complete the checks on residents with these devices that they ensured they were applied correctly.

Based on these observations, interviews and clinical record review the care set out in the plan of care, was not provided to the resident as specified in the plan for the specific device.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2014_326569_0009 as a VPC, June 9, 2015, in a Complaint Inspection #2015_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR) and June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC. (659)

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

Jun 30, 2017

Order # /
Ordre no : 011

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee will ensure the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change, for all residents and specifically:

a) That an identified resident is reassessed and the plan of care reviewed and revised related to eating assistance and nutritional care.

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, is implemented.

The licensee shall ensure there is a system in place to monitor that when a resident's care needs change, the resident is reassessed and the plan of care reviewed and revised, including who will be responsible for monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's nutritional care needs changed.

An identified resident was assessed by a Registered Dietitian (RD) as being at "High Nutritional Risk" due to a specified reason.

The clinical record showed this resident had a weight loss and the resident's weight was below their goal weight range.

The plan of care for this resident for "eating" documented that staff provided a specific level of assistance. The interventions included that PCP's were to report to registered staff any decrease in resident's ability to participate in eating activity. The plan of care for the resident also indicated a specific type of adaptive aid was to be used during meals and snacks.

Review of the assistance provided for nutritional intake and snacks documented on POC for this resident showed the resident was receiving a different level of assistance than what was identified in the plan of care for eating.

Observations during specified meals found the staff providing a different level of assistance to the resident than was identified in the plan of care. The resident was observed not to be using the adaptive aide that was included in the plan of care.

During interviews with multiple staff they stated that the resident had deteriorated and required an increased level of assistance with eating.The staff said they were not aware that the resident required the adaptive aide and acknowledged that this adaptive aid had not been used with this resident.

Based on these interviews and the clinical record review the plan of care for this resident was not revised when the resident's nutritional care needs changed. (659)

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2014_326569_0009 as a VPC, January 5, 2016, in a Complaint Inspection #2015_228172_0001 as a VPC, June 9, 2015, in a Complaint Inspection #2015_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, May 26, 2016, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR) and June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC. (630)

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

Jun 30, 2017

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 16 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMIE GIBBS-WARD - (A1)

Service Area Office /
Bureau régional de services : London