Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_536537_0037	002104-16, 015372-16, 029739-16, 032938-16, 034297-16, 034339-16, 035152-16, 035382-16, 000010-17, 001332-17, 004461-17, 005600-17, 005902-17, 006246-17, 007799-17, 008858-17, 010400-17, 010959-17, 011315-17, 015378-17, 016963-17	Complaint

Licensee/Titulaire de permis

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

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

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

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

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630), INA REYNOLDS (524), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, 27, 28, 29 and October 3, 2017

The following complaint inspections were conducted:

Related to the prevention of abuse:
Log #029739-16/C596-000070-16
Log #005902-17/IL-49873-LO
Log #034339-16/CC96-000103-16 submitted by the home r/t log #005902-17

Related to the prevention of abuse, falls management and plan of care:
Log #016963-17/IL-52037-LO
Log #010400-17/C596-000062-17 r/t log #016963-17

Related to staffing resulting in residents missing care:
Log #015372-16/Complaint Letters
Log #034297-16/IL-48401-LO
Log #035382-16/IL-48628-LO
Log #001332-17/IL-48883-LO

Related to medication administration, falls management, nutrition and hydration, housekeeping:
Log #002104-16/IL-42582-LO/IL-42680-LO

Related to not involving SDM in care decisions:
Log #032938-16/IL-48053-LO

Related to missing resident:
Log #035152-16/IL-48596-LO
Log #000010-17/C596-000114-16 r/t log #035152-16

Related to restraint use, medication administration, plan of care:
Log #005600-17/IL-49814-LO

Related to responsive behaviours:
Log #006246-17/IL-49965-LO

Related to falls prevention, pain management, skin and wound management, plan of care:
Log #007799-17/IL-50348-LO
Log #008858-17/C596-000055-17 submitted as a result of log #007799-17
Log #004461-17/C596-000025-17 submitted by the home r/t log #007799-17

Related to injury to a resident of unknown cause:
Log #011315-17/IL-51197-LO
Log #010959-17/C596-000064-17 r/t log #011315-17

Related to dealing with complaints, skin and wound management, dining and snack service, personal care:
Log #015378-17/IL-51817-LO/IL-51880-LO

A Written Notification related to LTCHA, 2007 c.8, s.20(1), identified in concurrent inspection #2017_536537_39 will be issued in this report.
A Written Notification related to LTCHA, 2007 c.8, s.6(7), identified in concurrent inspection #2017_537537_0039 will be issued in this report.
A Written Notice (WN) related to O. Reg. 79/10, s. 107(3)1, identified in this inspection will be issued under a Critical Incident inspection 2017_536537_0039 concurrently inspected during this inspection.
A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 8(1)(b) identified in concurrent inspection #2107_536537_0039 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Interim Directors, Coordinator St Mary's (SM), Coordinator Marian Villa (MV), Point Click Care (PCC) Support, Administrative Assistant, Quality Project Lead, Director of Facilities Management (DOFM), Assistant Coordinator of Care St Mary's, Assistant Coordinator Marian Villa, Registered Dietitian (RD), Coordinator Dietary, Manager Resident Services Sienna, Resident Assessment Instrument (RAI) Consultant, Human Resources Manager Medical Priorities, Coordinator Medical Priorities, Staff Educator, Scheduling Lead, Privacy Consultant St. Josephs, Detective London Police Services, Pharmacist, Bellwright, five Registered Nurses (RN), 16 Registered Practical Nurses (RPN), 34 Personal Care Providers (PCP), one Personal Care Assistant (PCA), one Housekeeping Aide, one Dietary Aide, one Therapeutic Recreation Aide, families and residents.

The inspector(s) also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed assessments, various policies and procedures of the home, training records and the home's internal plans, reviewed various meeting minutes, and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

The following evidence is further grounds to support the compliance order #010 related to LTCHA, 2007 c.8, s.6(7), issued on May 29, 2017, inspection #2016_457630_0045 with a compliance date of June 30, 2017.

A) A Critical Incident System (CIS) report was submitted by the home reporting an incident involving a resident.

Record review included an assessment of a risk level and interventions related to the identified risk.

A Registered Practical Nurse stated during an interview that they initiated the intervention as a result of the assessed risk level. The RPN said it was expected that staff would follow the interventions outlined in the care plan.

Coordinator Marian Villa acknowledged that the resident's plan of care included specific direction to staff, and that the care was not provided to the resident as specified in the plan of care. Coordinator Marian Villa said that it was the home's expectation that the care set out in the plan of care would be provided to the resident as specified in the plan.

B) A Critical Incident System (CIS) report was submitted by the home related to an incident involving a resident.

A clinical record review of the plan of care included specific interventions regarding monitoring of the identified resident. Review of the clinical record did not include documentation to support that the interventions as per the care plan had been implemented.

Review of the home's policy titled "Resident Monitoring & Rounds" revised date October 2016, stated that "hourly checks were completed on all residents to determine individual residents' whereabouts and safety at all times". Hourly checks were defined as visually observing the resident for safety on the unit, or "their whereabouts are clearly established" and that PCPs completing hourly checks would initial on the "Hourly Safety Checks" log sheet.

An RPN said that Personal Care Providers (PCP) were to complete hourly checks to verify the whereabouts of the resident and document on the "Hourly Safety Checks" record. PCP's said that they would complete hourly checks for the resident and document on their record.

Coordinator St. Mary's acknowledged that staff were to complete hourly checks as outlined in the plan of care to ensure that the whereabouts of the resident was known. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

This inspection was initiated as a result of a Critical Incident System (CIS) report and corresponding complaint related to falls prevention and management.

Record review of the plan of care for an identified resident stated under the Intentional Comfort Rounds (ICR) that the resident would receive ICR from staff. The plan of care directed staff to document the rounds on the paper log located in the resident's room.

Review of the Intentional Comfort Rounds Record stated that staff would complete rounds according to the schedule on the chart and assess the resident's needs. Staff were to initial and add the time to indicate that the Personal Care Provider had asked the resident all of the questions as listed on the form. The home's policy titled "Resident Monitoring & Rounds", revised date October 2016, stated that "Intentional Comfort Rounds (ICR) must be conducted 14 times in 24 hours on all residents that have been identified by the care team as needing additional monitoring."

A Personal Care Provider (PCP) told the inspector that scheduled comfort rounds included checking on the resident and asking the resident if they had any pain, if they were comfortable or if they required to be toileted. If the resident was sleeping they would not wake the resident, but would check the resident according to the frequency on the ICR log. After completion of the rounds, the PCP said they would document on the ICR record.

Review of the Mount Hope ICR Record for the identified resident showed there were a number of places on the ICR record with missing documentation during a specified time frame.

A Registered Practical Nurse (RPN) (RAI) acknowledged that documentation was missing on the ICR record. Coordinator Marian Villa told the inspector that the expectation was that staff were to document after completion of the comfort rounds.

The severity level was determined to be level two a minimal or actual potential for risk or harm. The scope was determined to be isolated. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2015_326569_0009 as a Voluntary Plan of Correction (VPC), June 9, 2015, in a Complaint Inspection #2105_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), June 7, 2016, in a Critical Incident Inspection #2016_217137_0014 as a VPC, and December 12, 2016 in a Resident Quality Inspection #2016_457630_0045, as a Director Referral (DR). [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Long-Term Care Homes Act (LTCHA), 2007, c. 8, s. 8(1) states in part that every licensee of a long-term home shall ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents; where personal support services is defined as services to assist with the activities of daily living, including personal hygiene services, and includes supervision in carrying out those activities.

A) The Ministry of Health and Long-Term Care (MOHLTC) received a complaint regarding the bathing care provided to an identified resident. The complainant stated that they were aware of the care issue identified and the specific interventions in place to assist in ensuring the care was provided.

The home's policy titled "Personal Resident Care: Bathing/Grooming", last revised in March 2017, stated in part that “if a resident who is not capable refuses personal care, the nurse consults the Substitute Decision Maker and proceeds as they direct. Document the Substitute Decision Maker’s wishes in the Progress Notes and in the Care Plan.”

A Mount Hope Documentation Survey Report v2 related to bathing for a specified time frame outlined the provision and outcome of attempts at bathing care, as per the policy, but there was no documented evidence that the interventions in the plan of care were implemented.

Coordinator of Marian Villa (MV) said that if a resident refused a bath, the PCP was to report the refusal to a registered staff member. The registered staff member would document the refusal and come up with a plan. Coordinator MV acknowledged that there were no documented responses by registered staff regarding specific outcomes of care for the identified resident.

B) Review of a Critical Incident System (CIS) report submitted by the home identified a medication incident involving an identified resident.

The home’s policy titled “Reporting and Review of Adverse Events and Near Misses/Patient Safety Reporting”, last reviewed September 11, 2015, stated; “it is the responsibility of any staff/affiliate who observes, is involved in, or made aware of an

adverse event or near miss to ensure it is reported in a timely manner either by entering it in the Patient Safety Reporting System (PSRS) or making the appropriate staff member aware."

Review of the progress notes for the resident showed a Patient Safety Reporting System (PSRS) was generated by a Registered Nurse and identified a medication incident involving the resident.

Review of the home's internal investigation notes, and interview with the Coordinator MV, determined that a Registered Practical Nurse (RPN) reported to Registered Nurse (RN) the medication incident. Further investigation found that the RPN had identified the error previously but did not correct the error, report to the RN or complete a PSRS themselves, resulting in the continuation of the medication not being administrated as ordered.

The Coordinator Marian Villa (MV) stated that when a medication incident was identified, the staff member who discovered the incident was responsible to report the error, either by reporting the information to the Charge Nurse, or by completing a Patient Safety Reporting System (PSRS) report. The Coordinator MV stated that once the PSRS was generated, the report was automatically sent to area leaders for review, and follow up as required would be initiated.

The Coordinator MV stated it was expected that the home's policy be followed to identify and address mediation incidents immediately.

The severity level was determined to be level one minimum risk. The scope was determined to be isolated. 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, on January 7, 2016 in a Complaint Inspection #2016_260521_0002 as a VPC, on May 26, 2016 in a Critical Incident Inspection #2016_226192_0022 as a Director Referral (DR), June 16, 2016 in a Complaint Inspection #2016_262523_0025 as a VPC, on June 7, 2016 in a Critical Incident Inspection #2016_217137_0014 as a VPC. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specified date, staff were unable to locate an identified resident. As a result, the home initiated their internal process to locate the resident, and began a search under a "code yellow". As a result of the search, the resident was located in a non-residential area.

Observation of the home area by Inspector #537 found the door was locked, and there was a sign posted on the door that stated, "Door to be locked at all times".

During interview, a Registered Nurse (RN) stated that the identified door was to be locked at all times. The RN stated that beyond the door was not a residential area that was not accessible to staff or residents. The RN stated that the Personal Care Providers (PCPs) do not have a key to the door, that a key was only available on the key ring held by the RN on duty. The RN demonstrated that at the time of observation, the door was locked, and opened and re-locked the door with the key they had. The RN also pointed out a sign posted on the door that indicated that the door was to be locked at all times. During interview with the Coordinator Marian Villa (MV), they stated that beyond the door was considered a non-residential area and was to be locked to prevent residents from entering.

Coordinator Marian Villa stated that when the resident was located, they were behind the door, and the door was not locked and should have been to prevent residents from entering the non-residential area.

The severity was determined to be level 2 minimal harm or potential for actual harm. The scope was determined to be isolated. There is a compliance history of this legislation being issued in the home on January 5, 2016 in a Resident Quality Inspection #2016_254_0001 as a Voluntary Plan of Correction and on December 12, 2016 in a Resident Quality Inspection #2016_457630_0045 as a Voluntary Plan of Correction. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian.

Record review of the Wound/Skin assessment for an identified resident indicated that the resident had a an area of altered skin integrity. The assessment indicated that a consultation was placed with the Dietitian.

Following interview with Registered Dietitian (RD), and record review of the progress

notes, the absence of a dietary referral and assessment for the identified area of altered skin integrity was determined. The RD stated that the resident was previously assessed and a risk level for skin integrity issues had been established. Review of the Dietary Assessment 1.0 tool referenced by the RD did not include the identified area of altered skin integrity for the resident.

Coordinator Marian Villa stated that the expectation was that registered staff complete a Dietitian referral under the "Referral to Food & Nutrition Services" in the progress notes in Point Click Care related to the identified area of altered skin integrity. Coordinator Marian Villa stated that they reviewed the progress note and a Dietitian referral was not completed by registered staff for the identified area of altered skin integrity for the resident. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, was reassessed at least weekly by a member of the registered nursing staff.

A written complaint letter was forwarded to the Ministry of Health and Long-Term Care related an area of altered skin integrity for an identified resident. The letter expressed that the resident had developed an area of altered skin integrity. Record review of the resident's electronic health care records on PointClickCare (PCC) showed that there was documentation that supported the identification of the area of altered skin integrity by staff.

The home's policy titled "Skin Care and Assessment, and Wound Management", revised in July 2014, stated that area of altered skin integrity would be assessed weekly and documented on the "Wound/Skin Assessment" in the electronic documentation system.

The resident failed to receive a weekly "Wound/Skin Assessment" on identified dates.

The Coordinator Saint Mary's acknowledged that there were missing weekly assessments for the resident's area of altered skin integrity, and that it was an expectation that they would be completed.

The severity was determined to be level one minimum risk. The scope was determined to be a pattern. There was a compliance history of this legislation being issued in the home on June 16, 2016 in a Complaint Inspection #2016_262523_0025 as a Written Notification, June 7, 2016 in a Critical Incident Inspection #2016_217137_0014 as a

Voluntary Plan of Correction. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian, and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff at the home performed their responsibilities before receiving training in the following areas: the Residents' Bill of Rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; and infection prevention and control.

Inspector #630 observed a caregiver working with a resident. The caregiver told Inspector #630 that they worked in the home through an agency as a companion to the resident and that they had been doing this for about a year.

Inspector #630 observed the caregiver working with the resident. The caregiver told Inspector #630 that they did receive orientation from the agency organization prior to starting but said this did not include education on Mount Hope's written policy on the prevention of abuse or neglect or the process for reporting.

Coordinator MV told Inspector #630 that the caregiver worked for an agency and did not receive training from Mount Hope regarding the home's written policy and procedures on prevention of abuse and neglect. When asked about the education provided to staff working through agencies in general, Coordinator MV said they were not sure if the agencies had received education packages but could find out from the Staff Educator. When asked about the orientation these staff received when they start working at Mount Hope, Coordinator MV said they have a booklet on the unit that outlined their duties and information on the resident but they did not participate in classroom training as the education was provided through the company they worked for, not from Mount Hope. During the interview, Coordinator MV called the Staff Educator and was told that the staff from this agency did not receive training within the home.

The Human Resources (HR) Manager of the agency told Inspector #630 that they had Personal Support Workers (PSWs) who worked at Mount Hope as caregivers as well as in Personal Care Provider (PCP) shifts. When asked about training that was provided to the agency staff, they said that when a PSW was hired, they received orientation from the agency and education on their internal policies. When asked if their staff received training on the Mount Hope policy on prevention of abuse and neglect, they said the agency staff had not been trained on this policy. When asked if the agency staff participated in classroom training or orientation when they started working at Mount Home from the home, HR Manager said they did not participate in that education.

The Staff Educator told Inspector #630 that the education provided to PSWs working in the home through agencies differed depending on the company. Staff Educator said that staff working through one of the agencies had to complete education provided through their agency which included an orientation package provided by Mount Hope prior to working in the home. Staff Educator said this education included information about the home's written policy on the prevention of abuse and neglect, the lift and transfer policy, restraints, personal care, responsive behaviours, documentation, falls prevention and fire safety. Staff Educator said other agency staff that the home contracted did not receive these materials as there had been a decision made by former Director that it was not necessary to provide to those companies.

The written training materials titled "Mount Hope Orientation for Comfort Keeper Staff", was provided to Inspector #630 by the Staff Educator. Review of this document showed that the information covered in this training did not include all areas required within the legislation. Specifically, these education materials did not include: all aspects of the Residents' Bill of Rights, as it partially listed four of the 27 rights; the duty under section 24 to make mandatory reports to the MOHLTC related to allegation of abuse or neglect; the "Whistle-blowing" protections afforded by section 26; and infection prevention and control practices within the home.

The Scheduling Leader said that PSWs from various agencies were scheduled for shifts at Mount Hope, either as caregivers or in PCP shifts a total of 96 shifts in a specified time frame.

Inspector #630 observed a caregiver providing care to an identified resident. The caregiver told Inspector #630 they had been working at Mount Hope through an agency for about two and a half years. The caregiver said that they thought they had received education on prevention of abuse and neglect about two and half years ago but did not recall the specific education provided about the Mount Hope policy on prevention of abuse and neglect. The caregiver said they had not received training from the home on infection control practices, the home's restraint policy, whistle-blowing protection, mandatory reporting of alleged abuse or neglect to the MOHLTC, Mount Hope's Mission Statement or the Residents' Bill of Rights.

The HR Manager from the agency told Inspector #630 that they had 54 PSW staff who had been working at Mount Hope. HR Manager of the agency said in the past, their staff did not receive training on Mount Hope's mission statement, the Residents' Bills of

Rights, Whistle-blowing protection, Mount Hope's minimizing of restraining policy, or Mount Hope's infection control practices before working in the home as one to one companions or in the PCP shifts.

The caregiver told Inspector #630 that they had participated in training on the Mount Hope policy for prevention of abuse and neglect. When asked if they had also received training on the home's policy on minimizing of restraining or infection control and prevention, the caregiver said they had not received that training.

Coordinator MV told Inspector #630 that it was the expectation in the home that all staff, including staff working through agencies, received the training required as stated in the legislation prior to starting their duties in the home. Coordinator MV said that they had recently started working on a plan to provide this education to all staff and acknowledged that this was not in place at the time of the inspection.

The severity was determined to be minimum risk. The scope was determined to be isolated. There was no compliance history of this legislation being issued in the home. [s. 76. (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 no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned: the Residents' Bill of Rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; and infection prevention and control, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following is further evidence to support Compliance Order (CO) #002 issued on May 29, 2017, in inspection #2016_457630_0045, with a compliance date of August 31, 2017.

A) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC). This report stated that a family member for a resident contacted the former Director and stated that "they received a report from someone" that there was a staff member that was potentially providing care to a resident in an abusive manner. This report also stated that the family member for the resident said this was reported to them by a staff member but they could not name the staff member. This report stated that as part of the investigation, an agency staff member was identified as having reported the allegation and was interviewed regarding the incident. This CIS report stated that the management in the home was made aware of the incident by the agency management and that management of Mount Hope reviewed the legislation related to abuse and immediate follow up, and information was provided to the agency leaders on who to contact when workers are in the building.

The home's policy "Abuse and Neglect of Residents: Zero Tolerance" with "Revised Date September 27, 2016" and "Reviewed Date November 8, 2016" included the following procedures:
-2.1.1 "All staff and affiliates are required to a) fulfil their legal obligation to immediately and directly report any alleged incident or witnessed incident of abuse or neglect to the Mount Hope leader/Clinical-on Call manager at pager 10580; and b) complete the form "Mount Hope internal Reporting of an alleged, suspected or Witnessed Abuse or Neglect of a Resident."

A family member for the resident told Inspector #630 that they had brought forward a

concern to the management in the home that they had heard from a caregiver that a staff member was providing care that could be considered as abusive.

The agency staff told Inspector #630 that they had concerns that the PCP had treated a resident in a manner that could be considered abusive. The agency staff said that at the time, they did not report the alleged abuse to anyone in the home or anyone at the agency with whom they were employed. The agency staff said that at a later time they reported the concerns to the family member of the resident. The agency staff said after they reported it to the family member for the resident, they were asked to write an incident report for the agency company and was interviewed by Coordinator MV regarding the incident. The agency staff said that they had not received education on the Mount Hope's policy on the prevention of abuse and neglect prior to starting to work and at the time of the incident was not aware of the home's policy regarding duty to report. The agency staff said they had an understanding of staff to resident abuse from their other work and the care that they observed did not sit well with their conscience. The agency staff said that they had been reluctant to report the incident at the time because they did not want to punish this staff member or get them in trouble.

Human Resources (HR) Manager of the agency told Inspector #630 that their staff were instructed to report any concerns with resident care to the nursing station and to also let the management know at the agency. HR Manager said that the staff would complete an occurrence form through the agency and then the management would get in touch with the Director at the home. HR Manager said that the agency staff member had brought forward a concern related to alleged abuse about two to three months ago. HR Manager said they thought that the staff member had reported it fairly quickly after the incident and then the occurrence form was completed. They said they personally got in contact with former Director shortly after they found out from the agency staff and the time frame was "maybe the next day or so" after. HR Manager said they were not aware of the details of Mount Hope's written policy on the prevention of abuse and neglect and had not personally received training on this policy.

Review of the home's records related to the reporting of the incident and subsequent investigation of alleged abuse for the CIS report included documentation of a phone call to Mount Hope management from family, an agency occurrence report, an email to management of Mount Hope from the management at the agency.

Coordinator MV told Inspector #630 that they were involved in the investigation into alleged abuse of resident by the staff member. Coordinator MV said that based on the

investigation there was not enough evidence to show that abuse had occurred. Coordinator MV said as part of the investigation they did interview the agency staff and this staff member did not come forward with the allegations of abuse immediately. Coordinator MV said when this staff member did bring forward the concerns, they did not speak with any staff or management in the home but instead spoke with a family member for the resident as well as the supervisor at the agency with whom they were employed. Coordinator MV said they received an incident report from the agency outlining the allegations brought forward by the agency staff. Coordinator MV said that they became aware of the allegations for the first time when family contacted Mount Hope.

Coordinator MV said it was the expectation in the home that all staff, including agency staff, would comply with the home's written policy on the prevention of abuse and neglect regarding duty to report any alleged incident of abuse or neglect immediately.

Based on these interviews and record reviews the licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

B) Review of a Critical Incident System (CIS) report submitted by the home showed that the Coordinator Marian Villa (MV) had been notified of an alleged incident of abuse, submitted by email and not reviewed and addressed immediately.

The home's policy titled "Abuse and Neglect of Residents: Zero Tolerance", Original Effective Date August 2001; Revised Date December 2015 included the following procedures:
"6. When ANY incident of alleged, witnessed or suspected abuse (of all types) 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; the RN will then...
-Monday to Friday, 8:00-4:00, call the Coordinator
-In the evening, at night, or on weekends, the building RN informs the Clinical-on-Call
-Include all such incidents on the 24-hr summative report.
9. The Coordinator or 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."

Coordinator MV stated that the staff who submitted the allegations of abuse had not notified the Clinical Registered Nurse (RN) or called the manager on call immediately to

report the allegations. Coordinator MV stated that they had not initiated an investigation immediately as they did not review the email immediately after it was sent, and an investigation was commenced once the email was reviewed.

Coordinator MV stated that it was the expectation that the home's policy on reporting 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.

C) Review of a Critical Incident Report submitted by the home showed that the Coordinator Marian Villa (MV) had been notified of an alleged incident of abuse of a resident, submitted by email and not reviewed and addressed immediately.

Coordinator MV stated that the staff had reported the allegation of the abuse towards to the Registered Practical Nurse (RPN) , who then reported to the Registered Nurse (RN). Coordinator MV stated that they met and interviewed the RN, and determined that the RN had followed the policy and had called the Clinical-On-Call to report, and stated that they did not get an answer or did not receive a return call. Coordinator MV stated that it was determined that the phone number the RN had was incorrect, and therefore the Clinical-On-Call did not receive a message, and an investigation was not initiated immediately, but was commenced when the email was viewed.

Coordinator MV stated that it was the expectation that the home's policy on reporting 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.

The severity was determined to be minimal harm or potential for actual harm. The scope was determined to be isolated. There was a compliance history of this legislation being issued in the home on December 7, 2015 in a Resident Quality Inspection #2015_260521_0057 as a Voluntary Plan of Correction (VPC), 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), on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC and on December 12, 2016 during the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, at least annually.

The family of an identified resident submitted a complaint to the Ministry of Health and Long Term Care Infoline, and indicated concerns regarding care decisions being made without consent of the family. The family of the resident stated that they had not had a care conference held annually to discuss the care of the resident.

Review of the assessments for this resident did not support that an Inder-Disciplinary Care Conference was held annually

During interview, the Assistant Coordinator for Resident Care St Marys indicated that each resident would have a care conference scheduled annually, after admission. They stated that the care conference would be documented under the assessment tab of Point Click Care, under the heading of Inder-Disciplinary Care Conference (Admission/Annual). Assistant Coordinator for Resident Care St Marys reviewed the master schedule of interdisciplinary care conferences and stated that a care conference had not been scheduled for the resident following the last recorded conference of greater than one year earlier, and that a care conference would be scheduled and the family invited to attend.

The severity was determined to be minimum risk. The scope was determined to be isolated. There was no history of this legislation being issued in the home. [s. 27. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review of the resident's electronic health records in PointClickCare (PCC) showed that the resident sustained falls on a specific date.

The home's policy titled "Falls – Assessment for Falls Risk and Management of Falls Events" revised in February 2015, defined a fall as any event that resulted in a person coming to rest inadvertently on the ground, the floor, or other lower level. This included near misses such as when a resident lost balance and would have fallen if staff did not intervene. The policy stated that when a fall occurred, the registered nurse or registered practical nurse would document the incident and the initial post-fall assessment of the resident using the post fall review/assessment tool in the electronic documentation system.

Review of the resident's online assessments showed no post-fall assessments were completed for the falls that occurred on the specified date.

Coordinator Saint Mary's acknowledged that a post fall assessment was not completed for the falls that occurred on the specified date, and that it was an expectation to be completed as per the policy.

The licensee failed to ensure that when resident a resident had fallen, a post-fall assessment was completed using a clinically appropriate assessment instrument specifically designed for falls.

The severity was determined to be level two, minimal harm or potential for actual harm. The scope was determined to be isolated. There was no history of this legislation being issued in the home. [s. 49. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to those behaviours, and actions were taken to respond to the needs of the resident, including reassessments.

The following is further evidence to support Compliance Order (CO) #007 issued on May 29, 2017, in inspection #2016_457630_0045, with a compliance date of June 30, 2017.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC). This report stated that there was an incident of resident to resident abuse.

The home submitted another CIS report to the MOHLTC on another date. This report stated that the identified resident was involved in an incident of resident to resident abuse involving a different resident.

The home submitted a third CIS report to the MOHLTC. This report stated that the identified resident was involved in an incident of resident to resident abuse involving an additional resident.

Review of the clinical record for the identified resident did not include assessments, reassessments, identification of triggers, development of interventions and strategies, or update of the plan of care for the resident until external resources were consulted after several incidents had occurred.

BSO Registered Practical Nurse (RPN) and BSO Personal Care Provider (PCP) told Inspector #630 that the identified resident had a long history of responsive behaviours and subsequent altercation with residents, some resulting in injury. They said that behavioural assessments and referrals to external resources were not completed until after there were several occurrences of responsive behaviours by the identified resident which resulted in changes to the plan of care. They said that after the internal referral was received, there were documented progress notes about the behaviours and strategies but no other assessments were done at the time of the incidents. Inspector #630 reviewed the plan of care for the resident with the BSO RPN and the BSO PCP and they acknowledged that this did not identify the risks or triggers related to resident to resident altercations until after several incidents had occurred. The BSO RPN said it was the expectation in the home that anytime there was an altercation between residents related to responsive behaviours that there would be reassessments completed, triggers identified, strategies developed and implemented to respond to the behaviours and responses to the interventions documented.

A PCP told Inspector #630 that the identified resident had a history of responsive behaviours and interventions that were in place and ineffective at preventing the responsive behaviours. The PCP stated they were aware of the incidents that occurred as outlined in the CIS reports submitted by the home.

Coordinator St. Mary's (SM) told Inspector #630 that the resident had a history of responsive behaviours towards other residents and identified triggers that caused the behaviours. Coordinator SM said they had attempted interventions that were not consented to by the family. They said that interventions they had implemented had not been successful . Inspector #630 reviewed the plan of care and documented assessments with Coordinator SM and they acknowledged that the behavioural triggers for the resident were not identified, strategies were not developed and implemented to respond to those behaviours, and reassessments were not completed after the initial resident to resident altercations. Coordinator SM acknowledged that the reassessments of the responsive behaviours had not been completed until long after the altercations had occurred. Coordinator SM said that it was the expectation that the plan of care would be reviewed and revised whenever there was an altercation between residents and that the triggers and interventions would be identified in the plan of care. Coordinator SM said that they had made significant changes to the program and policy and the process for identification of triggers, updating the plan of care for responsive behaviours and the completion of reassessments after altercations occurred had changed in response to CO

#007.

Based on these interviews and record review, the identified resident was demonstrating responsive behaviours which resulted in multiple altercations with other residents. At the time of the incidents the home did not identify the behavioural triggers for staff, strategies were not developed and implemented to respond to these behaviours after each incident or when the strategies that had been implemented were not effective, and actions were not taken to respond to the needs of the resident, including reassessments.

The severity was determined to be level two minimal harm or potential for actual harm. The scope was determined to be isolated. 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 and on December 12, 2016 in a Resident Quality Inspection #2106_457630_0045 as a Compliance Order. [s. 53. (4)]

Issued on this 30th day of November, 2017

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

Original report signed by the inspector.