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**

London Service Area Office
130 Dufferin Avenue 4th floor
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Facsimile: (519) 873-1300

Bureau régional de services de London
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LONDON ON N6A 5R2
Téléphone: (519) 873-1200
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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 12, 2018 | 2018_607523_0014 | 004260-18, 014251-18, 015340-18 | Critical Incident System |

## Licensee/Titulaire de permis

St. Joseph's Health Care, London
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

Mount Hope Centre for Long Term Care
21 Grosvenor Street P.O. Box 5777 LONDON ON N6A 1Y6

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

ALI NASSER (523)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 28, 29 and July 4, 2018.**

**Please note that a Written Notification issued in this inspection report is a supporting evidence for Compliance Order # 001, Inspection # 2018_729615_0014, Log # 028882-17, 028885-17, 028889-17, 002579-18, and a compliance date of June 26, 2018.**

**The following was completed during this inspection:**
**Critical Incident intake Log # 004260-18, CIS # C596-000020-18 related to a resident's fall.**
**Critical Incident intake Log # 014251-18, CIS # C596-000059-18 related to a resident's fall.**
**Critical Incident intake Log # 015340-18, CIS # C596-000062-18 related to a resident's fall.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, two Associate Director of Care, a Physician, six Registered Staff members and eight Personal Support Workers.**

**The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**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 home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date related to a resident's fall.

The CIS included information that on a certain date a specific resident had an unwitnessed fall after which the resident was transferred to hospital.

Clinical record review and staff interviews showed that the resident did not receive the level of supervision and assistance when ambulating around as set out in the plan of care.

On a certain date the ADOC said that the resident required a specific level of supervision and cueing as specified in the plan of care.

ADOC said that the care was not provided to the resident as it was set out in their plan of care. [s. 6. (7)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Clinical record review for a specific resident showed a progress note completed by specific RPN on a certain date indicated that the resident expressed specific signs and symptoms and required a treatment that needed a physician's order.

Clinical record review and staff interviews that the treatment was provided without a physician's order.

In an interview the ADOC said that it was the expectation that a physician's order would be obtained for the delivery of this treatment.

***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 drug is used or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.***

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**WN #3: 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. (5) The licensee shall ensure that on every shift,**
**(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action was taken as required.

Clinical record, progress note review for a specific resident showed that on a specific date the resident expressed signs and symptoms of infection.

A review of the home's policy "Surveillance and Process of Data Collection" reviewed February 2018 stated in part "Procedure: The registered staff will: 1) Monitor all residents for signs and symptoms of infection, 2) Complete the Daily Infection Control Surveillance Record, 3) Ensure that the appropriate transmission-based precautions are implemented immediately should any pattern of symptoms suggest an outbreak is in progress, 4) Note any patterns of symptoms and report these to the Infection Control Practitioner/designate".

ADOC reviewed clinical record with inspector and said that there was no documented evidence that the resident's symptoms of infection were monitored and recorded on every shift on the Daily Infection Control Surveillance Record or progress notes in Point Click Care (PCC) and that it would be expected that the symptoms of infection be monitored and documented on every shift and on the Daily Infection Control Surveillance Record and PCC. [s. 229. (5) (a)]

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**Issued on this 12th day of July, 2018**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ALI NASSER (523) |
| **Inspection No. / No de l'inspection :** | 2018_607523_0014 |
| **Log No. / No de registre :** | 004260-18, 014251-18, 015340-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jul 12, 2018 |
| **Licensee / Titulaire de permis :** | St. Joseph's Health Care, London<br>268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2 |
| **LTC Home / Foyer de SLD :** | Mount Hope Centre for Long Term Care<br>21 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-1Y6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Ruthanne Foltz |

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)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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 / Ordre :**

The licensee must be compliant with s.6 (7) of the Act.
Specifically the licensee must ensure that all residents receive the required level of supervision and/or assistance while ambulating as set out in the plan of care.

**Grounds / Motifs :**

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 home submitted Critical Incident System (CIS) report # C596-000059-18 to the Ministry of Health and Long-Term Care (MOHLTC) on June 19, 2018, related to a resident's fall that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident 's health status.

The CIS included information that on June 18, 2018, at 1315 hours resident #001 had an unwitnessed fall. Resident was found sitting in the hallway, resting their head on their walker. The resident was holding the rails on the walker and calling for help. Resident sustained a small skin tear to the right side of their head, however no other visible injuries. Resident was transferred to bed with lift. Resident began complaining of hip pain at this time. The resident was transferred to hospital at 1420 hours with possible fracture.

On June 28, 2018, PSW #103 said in an interview that the resident was a high risk for falls and they required supervision when walking around with the walker. PSW #103 said that they were working on the day of the incident. They said that they were in the dining room at the end of the lunch service and were busy finishing lunch and feeding residents.

PSW #103 said the resident was not supervised as per the plan of care when they got out of the dining room and went for a walk.

On June 28, 2018, PSW #106 said in an interview that the resident was high risk for falls, the resident used their walker and sometimes a wheel chair to move around.
PSW #106 said that the resident required supervision when using a walker.
PSW #106 said that they were working on the day of the incident, the resident just got up, used the walker and left the dining room. PSW said that they were busy and did not see the resident and the resident was not supervised when walking around with the walker.

On June 28, 2018, RPN #102 said in an interview that the resident was a high risk for falls, the resident required supervision when walking using the walker.
RPN #102 reviewed the plan of care and said that the resident was supposed to be supervised when they were using their walker.

On June 28, 2018, ADOC #101 said that the resident was a high risk for falls and required supervision and cueing while using a walker.

The ADOC reviewed the resident's care plan with inspector. The care plan showed the Focus: "requires assistance for walking and/or wheelchair mobility related to loss of muscle strength and flexibility, decreased balance.
Intervention: Walking-Staff provide supervision (oversight/encouragement/cueing) as resident ambulates using walker. Limited staff assistance PRN. Walking-staff will observe ambulation for endurance and steadiness, report change in gate to Registered Staff".

ADOC said that the care was not provided to the resident as it was set out in their plan of care, as resident did not receive assistance or supervision when they were walking.

The severity of this issue was determined to be a level 3, actual harm/risk. The scope of the issue was a level 1 as it was isolated. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
Written Notification and Voluntary Plan of Correction issued on November 16,

2017, (2017_536537_0037).
Written Notification and Compliance Order issued on November 16, 2017, (2017_536537_0035). The Compliance Order was complied with on January 2, 2018.
Written Notification and a Director Referral issued on May 29, 2017, (2016_457630_0045).
Written Notification and Voluntary Plan of Correction issued on October 20, 2016, (2016_217137_0014).
Written Notification and a Director Referral issued on October 3, 2016, (2016_226192_0022).
Written Notification and Voluntary Plan of Correction issued on January 28, 2016, (2016_254610_0001).
(523)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2018

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  12th  day of July, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Name of Inspector / Nom de l'inspecteur :** Ali Nasser

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