Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 22, 2019	2019_607523_0033	007614-19, 011695-19, 012064-19, 013268-19, 013631-19	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), INA REYNOLDS (524)

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): July 10 and 11, 2019.

The following intakes were completed during this inspection:
Follow Up Log # 007614-19, FU to CO#002 from inspection #2019_788721_0009 related to policy to promote zero tolerance of abuse and neglect.
Critical Incident Log # 013268-19, CIS # C596-000072-19 related to a resident's fall.
Critical Incident Log # 012064-19, CIS # C596-000069-19 related to a resident's fall.
Critical Incident Log # 011695-19, CIS # C596-000067-19 related to a resident's fall.
Critical Incident Log # 013631-19, CIS # C596-000074-19 related to a resident's fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staff Educator, five Registered staff members, three Personal Support Workers and two residents.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific 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.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 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.O. 2007, c.8 s. 20. (1)	CO #002	2019_788721_0009	524

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 s. 48. (1) 1 states "every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a certain date. The CIS included information that the resident had a fall on certain dates.

A review of the home's policy subject Head Injury Routine Guidelines. Revised June 2014, showed procedure items that included the following:
"#1: if the resident does not require emergency medical intervention for the fall but has hit his/her head or is suspected of hitting his/her head, the nurse documents the above assessment in the Progress Notes and completes a neurological status check as per the Neurological Record. (see also #3).
#3: after the initial assessment, neuro checks are then completed:
• every hour for 4 hours then
• every 4 hours x 5 (20 hours total)
• every 8 hours x 3 (24 hours total) "

Clinical record review showed that the resident had two falls on specific dates that required the Head Injury Routine to be initiated.
A review of the Neurological Record for those falls showed that checks were not completed as per the home's policy.

The Director of Care (DOC) reviewed with the inspector the progress notes and the Neurological Records for the two specific falls.
The DOC said in an interview that the Neurological Records were missing checks and were not completed as per the policy of the home. DOC said that the expectation was for the staff to complete checks as directed in the policy and for the staff to comply with the home's policy. [s. 8. (1) (a),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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

Issued on this 22nd day of July, 2019

[redacted]

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

Original report signed by the inspector.