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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 7, 2019	2019_819524_0002	014495-19, 016264-19, 017222-19, 017235-19, 017699-19, 018241-19	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

INA REYNOLDS (524), AYESHA SARATHY (741)

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): September 9, 10, 11, 24, 26, 27 and 30, 2019.

The following Critical Incidents were completed within the Inspection:
Log #014495-19 / CIS #C596-000078-19 related to the medication management system
Log #016264-19 / CIS #C596-000084-19 related to falls prevention and management
Log #017222-19 / CIS #C596-000087-19 related to falls prevention and management
Log #017235-19 / CIS #C596-000088-19 related to falls prevention and management
Log #017699-19 / CIS #C596-000090-19 related to prevention of abuse
Log #018241-19 / CIS #C596-000093-19 related to prevention of abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Interim Director of Care, two Associate Directors of Care, the Administrative Assistant, the Resident Family Liaison, four Registered Practical Nurses, eight Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions and a medication storage area. Inspectors reviewed residents' clinical records, internal investigation notes and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (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 resident's plan of care was revised when the resident's care needs changed.

On a specific date, the home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MOLTC), related to an allegation of abuse reported by an identified resident.

The Acting Director of Care (Acting DOC) #105 completed and submitted the CI report to the MOLTC and documented in the report that the care plan had been updated to reflect specific identified care for the identified resident. The resident's care plan and Kardex were reviewed by the inspector in Point Click Care (PCC) and there was no evidence that either document had been updated to reflect the identified care for the resident.

During an interview, when Personal Support Worker (PSW) #116 was asked how a staff member would know that the resident's care needs had changed to receiving the specific care, they stated that the information would be updated in the resident's care plan. In another interview with the Acting DOC #105, they indicated that the update on the resident's care was included in their care plan. Acting DOC #105 reviewed the resident's care plan and Kardex in the presence of the inspector and agreed that both documents had not been updated to indicate the specific care to be provided for the resident. Acting DOC #105 stated that they asked nursing staff to update the resident's care plan immediately following the incident but staff failed to do so.

The license failed to ensure that the identified resident's plan of care was revised when the resident's care needs changed. [s. 6. (10) (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 the resident's plan of care is revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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. Specifically, staff failed to comply with the home's "Prevention of Abuse and Neglect of a Resident" policy (last revised June 2019).

The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MOLTC) related to an allegation of abuse reported by an identified resident.

The resident's clinical record was reviewed by the inspector on Point Click Care (PCC) and progress notes documented on identified dates, stated that the resident was emotionally upset and shaken by the incident they had reported. During interviews, Personal Support Worker (PSW) #106 and #116, Registered Practical Nurse (RPN) #107 and Acting Director of Care (DOC) #105 all said that the resident was upset and a bit shaken after the incident. They said that the resident brought up the incident with staff members for days after it took place. PSW #116 said that it would be a good idea to have someone follow up with the resident to see how they were doing.

The inspector interviewed the resident on a specific date, sixteen days after the incident

of alleged abuse occurred. The resident told the inspector that they were not sure if they felt safe in the home and that they had felt stressed every time someone came into their room.

The home's policy titled "Prevention of Abuse and Neglect of a Resident", last revised June 2019, stated under "Procedure" that: "The Resident/Family/Representative and alleged abuser may be offered emotional support and provided with a list of internal resources, including the Social Worker/Social Services Worker, spiritual care, and external local resources as available."

The inspector also reviewed a document titled "Checklist for Investigating Alleged Abuse of Resident by: Family or Staff or Visitor or Volunteer or Another Resident", last revised August 2019. The checklist was completed as a part of the home's investigation into the resident's allegation of abuse and documented that a referral was made to a Social Services Worker (SSW) #111 under checklist item "Provide referral information for Abuse counseling and offer to arrange additional emotional counseling and support to the resident and family and staff as necessary".

In an interview with SSW #111 on a specific date, they said that a part of their role in the home was to provide practical supports for residents in the home, which included determining whether they need spiritual care, other community supports, and to listen and provide coping strategies. SSW #111 said they received a referral via phone call from the Acting DOC #105 after the alleged incident occurred requesting that emotional support be provided to the resident for a few days. SSW #111 said they attempted to meet with the resident in their room on a specific date, however, were unable to talk to the resident as they were asleep at the time. Eight days later, on a specific date, SSW #111 ran into the resident in a common area in the home and had a conversation with the resident. When asked whether SSW #111 discussed the incident of alleged abuse with the resident, they said they did not as the resident did not bring it up. When asked whether additional supports were offered to the resident, SSW #111 said that the resident did not seem to be impacted by the incident and was not distressed, therefore, additional support was not offered. SSW #111 also said that they did not plan on following up with the resident again as they did not feel it was necessary after reading the resident's chart.

Acting DOC #105 acknowledged in an interview with the inspector that emotional and practical supports were not offered to the resident and that it was the home's expectation that SSW #111 would have followed up with the resident and provided support.

The licensee failed to ensure that staff complied with the home's "Prevention of Abuse and Neglect of a Resident" policy to offer emotional support and provide a list of internal and external resources to the identified resident. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 22nd day of October, 2019

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

Original report signed by the inspector.