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
Nov 28, 2019	2019_722630_0034	019005-19, 019194-19, 019435-19, 019590-19, 020507-19	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

AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689)

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): November 21, 22, 25, 26 and 27, 2019.

The following Critical Incident System intakes were completed within this inspection:
Log #019005-19 / CI C596-000098-19 related to falls prevention and management;
Log #019194-19 / CI C596-000099-19 related to an incident which resulted in a hospitalization or significant change of condition;
Log #019435-19 / CI C596-000101-19 related to alleged staff to resident abuse;
Log #019590-19 / CI C596-000103-19 related to falls prevention and management;
Log #020507-19 / CI C596-000108-19 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Directors of Care (ADOC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Worker (PSWs) and residents.

The inspectors 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 and reviewed relevant policies and procedures of the home.

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

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)**

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a specific resident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC) related to a fall for a specific resident which resulted in an injury.

The home's policy Lifts and Transfers with revised date August 2019, included "all staff must follow the Care Plan for each individual resident, in terms of what type of lift or transfer is to be used with the resident on a daily basis."

The clinical record for this resident showed that prior to the fall the resident had been assessed to require a specific type of assistance from staff with transfers and this was included in the plan of care.

During an interview with an identified staff member they stated they responded to the fall and had completed the post-fall assessment. The staff member said that this resident required a specific type of assistance with transfers and this had not been provided to the resident. The staff member said that they would expect that the staff member had used safe transferring techniques and devices as specified in their plan of care when assisting this resident during the transfer.

During an interview with an Associate Director of Care (ADOC) they said they were familiar with this resident and the fall that had been reported to the MOLTC. The ADOC stated that at the time of the fall, the resident's plan of care indicated that they required a specific type of assistance with transfers. The ADOC said this resident did not receive that assistance on the day of the incident and they would expect that the staff would have used safe transferring techniques as specified in their plan of care.

The licensee had failed to ensure that staff used safe transferring techniques when assisting this specific resident and the resident sustained a fall which resulted in an injury. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 28th day of November, 2019

[redacted]

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

Original report signed by the inspector.