Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 8, 2021	2021_886630_0020	001504-21, 002926-21, 005551-21, 005999-21, 006664-21, 007782-21, 008256-21	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), ALI NASSER (523), CHRISTINA LEGOUFFE (730)

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): May 18, 19, 20, 25, 26, 27, 28, 31, June 1 and 2, 2021.

The following Critical Incident (CI) intakes were completed within this inspection:

Related to falls prevention and management:
Log #001504-21 / C596-000007-21
Log #007782-21 / C596-000019-21

Related to the prevention of abuse and neglect:
Log #002926-21 / C596-000012-21
Log #005551-21 / C596-000015-21
Log #006664-21 / C596-000017-21
Log #008256-21 / C596-000022-21

Related to Hypoglycemic Event:
Log #005999-21 / C596-000016-21

An Infection Prevention and Control (IPAC) inspection was also completed.

Inspectors Loma Puckerin (#705241) and Angela Finlay (#705243) were also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Associate Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Housekeeper, Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed medication administration, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes, reviewed staff training documents and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
4 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. (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 plan interventions for continence care were provided to a resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC). At the time of this incident, staff had provided care to the resident in a way that was not in accordance with their plan of care. The Director of Care (DOC) said it was the expectation in the home that the care was to be provided to the resident as specified in the plan of care.

Sources: The resident's plan of care and clinical records, the CIS report and staff interviews. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care intervention for responsive behaviours was provided to a resident as specified in the plan of care.

A CIS report was submitted to the MLTC related to a specific incident between residents. At the time of the incident an interventions that was in place for one of the residents was not being provided. An Associate Director of Care (ADOC) said that this intervention was required for the resident at the specified time to minimize risks of altercations with other residents. The ADOC said the care was not provided to the resident as specified in the plan of care.

Sources: The resident's plan of care, CIS reports and staff interviews. [s. 6. (7)]

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 residents 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 policies or procedures included in the Falls Prevention and Management program were complied with for a resident who had a fall.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to be developed and implemented in the home to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10, s. 49 (2) requires that the home to 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.

Specifically, staff did not comply with the home's "Falls: Assessment for Fall Risk and Management of Fall Events" policy and procedures as it required Personal Support Worker (PSW) staff to ask the resident not to move, find a Registered Nurse (RN) or Registered Practical Nurse (RPN) right away to assess the resident. It also required that whenever a resident was found, having fallen or suspected of having fallen, the person who found the resident was to assesses the situation immediately and to use a mechanical lift to lift the resident off the floor if they usually required a mechanical lift for transfers.

A resident had a fall and a staff member had been present with the resident at the time of the fall. The staff did not report the fall to the registered nursing at the time of the fall and therefore the resident was not assessed in accordance with the home's policy. The staff also did not lift the resident off the floor in accordance with the policy. Based on the home's ongoing investigation into this fall it was identified that resident the resident experienced a significant change in health status related to the fall.

Sources: A Critical Incident System (CIS) report; the resident's post fall assessment and other clinical records; the home's Resident Incident Report; the home's "Falls: Assessment for Fall Risk and Management of Fall Events" policy dated August 14, 2019; interview with an Associate Director of Care (ADOC) and other staff. [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, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the licensee ensures that the policy or procedure is complied with, to be implemented voluntarily.

WN #3: 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 resident.

A staff member assisted a resident to move from one position to another without the use of the required equipment and without another staff member present. The resident fell and experienced a significant change in health status resulting from the fall. The staff did not use safe transferring techniques as per the home's Lifts and Transfers policy. The resident's transfer care requirements had previously been assessed and their plan of care directed that the resident required specific assistance from two staff with transferring from one position to another using a specific type of equipment. During the home's investigation it was determined that the staff had been trained on these requirements and were aware of the resident's plan of care. The staff did not comply with the safety requirements of the home and this caused harm to the resident.

Sources: A CIS report; the resident's plan of care and other clinical records; the home's Resident Incident Report; the home's "Lifts and Transfers" policy dated September 4, 2019; interview with an Associate Director of Care (ADOC) and other staff. [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.

WN #4: 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 had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policy titled "Falls: Assessment for falls risk and management of fall events" indicated when a fall had occurred, or a resident was suspected of having fallen, the staff were to document the incident and the initial post-fall assessment of the resident using the Post-Fall Review/Assessment tool in the electronic documentation system.

A review of the resident's clinical records showed the resident had reported to staff that they had fallen. There was no post fall assessment documented for this fall. During an interview with a registered nursing staff member and the Director of Care (DOC) they said if a resident self-reported a fall the same instructions were to be followed as if it were a witnessed fall. The lack of post fall assessment placed the resident at risk for harm as it impacted on the staff's ability to understand how the resident fell and any injuries sustained.

Sources: The home's Fall: Assessment for Falls Risk and Management of Fall events policy dated last updated August 2019; the resident's progress notes and other clinical records; interview with the DOC and other staff. [s. 49. (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 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, to be implemented voluntarily.

Issued on this 15th day of June, 2021

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

Original report signed by the inspector.