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
Feb 4, 2021	2021_722630_0006	023213-20, 024532-20, 025356-20, 025530-20, 001469-21	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), DONNA TIERNEY (569)

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): January 26, 27, 28, 29 and February 1 and 2, 2021.

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

Related to falls prevention and management/change of condition & hospitalization:
Log # 024532-20 / C596-000064-20
Log # 025356-20 / C596-000066-20
Log # 025530-20 / C596-000067-20
Log # 001469-21 / C596-000005-21

The following Follow-up intake was completed within this inspection:
Log # 023213-20 for CO #001 from Inspection #2020_777731_0024 related to skin and wound care.

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

The inspectors also observed resident rooms, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed Critical Incident (CI) reports 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
Infection Prevention and Control
Skin and Wound Care

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

- **1 WN(s)**
- **0 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
O.Reg 79/10 s. 50. (2)	CO #001	2020_777731_0024	630

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. 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.

A resident had multiple unwitnessed falls in the home during a specific shift. The registered nursing staff who responded to the resident's falls completed aspects of a post fall assessment for each fall, but did not fully complete or document the required post-fall assessments using the home's assessment instrument. An Associate Director of Care (ADOC) said the home completed an investigation and found that the post fall assessments for the resident were not completed in accordance with the expectations of the home and they were planning to provide further training to staff. The ADOC said their investigation also identified some miscommunication between staff related to the resident's falls. The incomplete post fall assessments placed the resident at risk for harm as it impacted on the staff's ability to understand the resident's condition and risks associated with the falls and potentially impacted on accurate communication regarding the post-fall assessments conducted in the home.

Sources: A Critical Incident System (CI) report; the resident's progress notes and other clinical records; interviews with an Associate Director of Care (ADOC) and other staff. [s. 49. (2)]

Issued on this 4th day of February, 2021

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

Original report signed by the inspector.