Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Original Public Report

Report Issue Date: March 11, 2024	
Inspection Number: 2024-1520-0002	
Inspection Type: Critical Incident	
Licensee: St. Joseph's Health Care, London	
Long Term Care Home and City: Mount Hope Centre for Long Term Care, London	
Lead Inspector Ali Nasser (523)	**Inspector Digital Signature** Ali Nasser Digitally signed by Ali Nasser Date: 2024.03.11 15:14:00 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 2024

The following intake(s) were inspected:

- Intake: #00106659, related to unexpected death of a resident.
- Intake: #00108241, related to a resident's fall.
- Intake: #00109046, related to alleged staff to resident abuse.

Inspectors Stephanie Newton (000820) and Mark Smith (000815) were present during this inspection.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in a resident's plan of care was based on an assessment of the resident and on the needs and preferences of the resident.

Rational and Summary:
Observations during the inspection showed the resident had a specific intervention applied.

In interviews with staff members they said the resident preferred to have this intervention applied. They confirmed the plan of care did not include any direction for staff to apply this intervention.

The Assistant Director of Care (ADOC) and a Registered Nurse (RN) confirmed with the resident that their preference was to have this intervention.

The ADOC said the plan of care should have been based on the resident's preference and the intervention should have been part of the plan of care. ADOC updated the plan of care.

Sources: clinical record and staff interviews. [523]

Date Remedy Implemented: March 8, 2024

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report to the Director on related to an unexpected or sudden death of a resident that occurred a day earlier.

In an interview the Administrator said the incident was a sudden death of the resident and it was not reported immediately to the Director. They expected the Director to be informed immediately if there was an incident of unexpected or sudden death.

Sources: record reviews and interview. [523]