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

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Original Public Report

Report Issue Date: November 25, 2024
Inspection Number: 2024-1520-0006
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-8, 12-14, 2024

The following intake(s) were inspected:

- Intake: #00127409 related to abuse and neglect of a resident.
- Intake: #00127312 related to Infection Prevention and Control.
- Intake: #00127675 related to Infection Prevention and Control.
- Intake: #00127839 related to Infection Prevention and Control.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure that they complied with their written policy to promote zero tolerance of abuse and neglect of residents.

Rationale/Summary
A Critical Incident System (CIS) report was received by the Director as a result of suspected staff to resident abuse and neglect.

Review of resident clinical records indicated that a resident sustained an unwitnessed fall.

Review of the home's investigation notes indicated that a staff member observed a resident on the floor for an extended period of time.

Review of the home's Prevention of Abuse and Neglect of a Resident policy stated that if staff have any knowledge of an incident that constitutes resident abuse or neglect, they were required to immediately inform their supervisor who would inform their leader and/or the clinical on-call and/or Executive Director or designate in charge of the home

Review of a staff member's email indicated their concerns with the care provided to

a resident and was not sent to the Registered Nurse or on-call manager as per the home's policy.

During an interview with a Resident Care Manager they stated that staff were required to immediately escalate the concern to the Registered Nurse or call the on-call manager and confirmed that staff did not report the incident as per the home's policy.

There was an increased risk to the resident's safety when the suspected incident of abuse and neglect was not reported as per the home's policy.

Sources: Review of Critical Incident System (CIS) report, resident clinical records, Prevention of Abuse and Neglect Policy, home's investigation notes, staff email, and interviews.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's Falls Prevention and Management policy related to head injuries for a resident.

In accordance with O.Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and

management program and ensure that they are complied with. Specifically, registered staff did not comply with the licensee's head injury routine protocol as part of the post-falls assessment.

Rationale/Summary
Review of a resident's clinical records indicated that they sustained an unwitnessed fall. A resident was unable to state how they ended up on the floor or the reason for the fall.

Review of the home's Head Injury Routine Guidelines policy stated that if the nature of the fall cannot be determined, the registered staff are required to document the assessment in the progress notes and complete neurological status checks as per the head injury routine record.

During an interview with a Registered Practical Nurse they acknowledged that they did not initiate a head injury routine for a resident. During an interview with Resident Care Manager they confirmed that a Registered Practical Nurse did not initiate a head in jury routine for a resident and should have as per the home's policy.

The home's failure to complete a resident's neurological assessment immediately post-fall, to identify changes in their level of consciousness, placed the resident at an increased risk.

Sources: Review of resident clinical records, the home's Head Injury Routine Guidelines policy, and staff interviews.