Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 15, 2014 | 2014_183135_0064 | 000354-14 | 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

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S
21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BONNIE MACDONALD (135)

### 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): August 12, 2014.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Coordinator of Resident Care, 2 Registered Nurses, Registered Practical Nurse, Behavioural Supports Ontario Personal Support Worker, Social Worker, Personal Care Provider and Resident.**

**During the course of the inspection, the inspector(s) reviewed resident clinical records, staff training records and procedures for Abuse and Neglect and Responsive Behaviours. Observed resident care and services provided in resident home area.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include:

* assessment
* reassessments
* interventions, and
* documentation of the resident's responses to the interventions

Record review revealed that Resident #01 had been exhibiting escalating behaviours.

Resident was assessed by the home's Social Worker as requiring a specialized assessment following an incident with the resident.

During an interview with Registered Staff and following a record review, it was revealed that resident continues to exhibit behaviours and has not been referred for the specialized assessment.

In an interview the Coordinator Resident Care confirmed her expectation that the actions taken to meet the needs of the resident with responsive behaviours include reassessments. [s. 53. (4) (c)]

**Issued on this 18th day of August, 2014**

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