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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 05, 2015;	2014_242171_0007 (A4)	L-000485-14	Resident Quality Inspection

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 - MARIAN VILLA
200 COLLEGE AVENUE P.O. BOX 5777 LONDON ON N6A 1Y1

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

DONNA TIERNEY (569) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

This inspection report and order report have been changed to extend the compliance date for Order #005 related to Administrator hours to January 1, 2016.

Issued on this 5 day of August 2015 (A4)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 05, 2015;	2014_242171_0007 (A4)	L-000485-14	Resident Quality Inspection

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 - MARIAN VILLA
200 COLLEGE AVENUE P.O. BOX 5777 LONDON ON N6A 1Y1

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

DONNA TIERNEY (569) - (A4)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 13-16, 20-23, 26, 2014

This inspection was conducted concurrently with Complaint Inspection L-000249 -14

During the course of the inspection, the inspector(s) spoke with the Acting Director/Vice-President of Complex, Speciality Aging and Rehabilitative Care, 2 Coordinators, Resident Care, Director of Facilities Management, 2 Coordinators of Facility Management, 2 Coordinators of Housekeeping, Coordinator of Food and Nutrition, 2 Resident Council Liaisons, Nurse Educator, 2 Food Service Technicians, Registered Dietitian, Office Manager, Occupational Therapist, Physiotherapy Assistant, 4 Registered Nurses (RN), 13 Registered Practical Nurses (RPN), 16 Primary Care Partners (PCP), Housekeeper, 2 Dietary Aides, Family Council President, Residents' Council Co-Chair, Family members and Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **21 WN(s)**
- **14 VPC(s)**
- **5 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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Home was kept clean and sanitary.
This same finding was issued as a Voluntary Plan of Correction on June 20, 2013 after a Complaint Inspection and June 6, 2012 after a Resident Quality Inspection.

On May 13, 2014 at 1000 a tour and observations in the home revealed the following:
- The armchair beside the elevator doors was visibly soiled on 1st floor
- Air vents were very dusty in 1st floor dining room
- Ceiling vent was visibly thick with dust in the 5th floor tubroom
- Air vent above toilet was visibly dusty in resident bathroom
- Air vents mounted on the counter behind a sink and two under the counter vents were visibly dusty and rusted in the 4th floor lounge
- Dead bugs were observed in the ceiling lights in the 4th floor lounge and 5th floor resident bathroom
- Underneath peeled wallpaper were 2 crawling insects in the 2nd floor dining room

Observations made during Stage 1 of the inspection included:
- dead bugs in the ceiling lights above resident's beds and in resident's bathrooms
- ceiling vent in bathroom visibly thick with dust
- spills on radiator in the 4th floor lounge
- odour in 4th floor lounge

On May 20, 2014 at 1100, a tour and observations in the home with the Environmental Services Coordinator revealed:

- numerous dead bugs in the ceiling light fixtures in hallways and resident's rooms in various locations throughout the home
- stained ceiling tiles in various areas throughout the home
- a bad odour in some areas
- air vents very dusty in numerous areas of the home

In an interview with Environmental Services, it was confirmed that this is a limited listing of the concerns that were found during the tour and observations.

The Environmental Services Coordinator confirmed the expectation is that all home areas and resident rooms are kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that the Home was kept in a good state of repair.

On May 13, 2014 at 1000 a tour and observations in the home revealed the following:

- Hallways had many areas of paint and plaster peeling and doors scraped on 1st floor
- Chipped paint on walls and stained ceiling tiles in family dining room on 1st floor
- Paint chips below chair rail and between elevator doors and across from nurses station on 2nd floor
- Paint scraped below chair rails and gouged between elevator doors and across from nurses station on 3rd floor
- Plaster missing above radiator, paint chipping above baseboard on wall and end of room, baseboard broken and pulled away from wall at servery in dining room on 4th floor
- Paint peeling on the wall beside the television and unpainted under windows and behind arm chair, and radiator paint peeling off in resident lounge on 4th floor
- The bottom shelf had peeling metal and rust in a shared bathroom cabinet. Soap holder beside the sink was loose and pulled away from the wall, grab bar behind toilet was corroded.

Multiple examples of chipped, scraped and gouged walls, doors and door frames in resident's rooms on all floors of the home.

On May 20, a home tour and observation with the Facilities Engineering Coordinator revealed:

- Ground floor – the baseboard on the wall between the elevators was peeling off.
- 2nd floor- Z215 Bathing Suite - door frame scraped and chipped, paint peeling off the ceiling and hole in the ceiling.
- 2nd floor- wall damage on the wall in hallway, a hole in the drywall, paint scraped off door frame.
- 3rd floor - Z315 Bathing Suite - plastic siding of door frame was off and scrapes on walls
- 5th floor- numerous locations: plastic protection on wall corners were broken.
- 5th floor- scrapes on walls, doors and door frames.

In an interview with Facilities Engineering Coordinator it was confirmed that this is a limited listing of the items that are in need of repair and that numerous other examples had been noted by the inspectors during the course of this inspection. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that procedures were in place for routine, preventive and remedial maintenance as part of the organized program of maintenance services. This same finding was issued as a Voluntary Plan of Correction on June 6, 2012 following a Resident Quality Inspection.

On May 20,2014 at 1030, a home tour and observation with the Facilities Engineering Coordinator confirmed wall, baseboard, door and ceiling damage on all resident home areas as noted above in s. 15(2)(c).

In an interview with the Facilities Engineering Coordinator it was confirmed that this list of items is reflective of a lack of routine, preventative and remedial maintenance.

On May 20, 2014 a review of the preventative maintenance program with the Facilities Engineering Coordinator revealed that the home does not have policies and procedures as part of the preventative maintenance program. This was also confirmed by Facilities Engineering Director. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff participated in the implementation of the infection prevention and control program.
This same finding was issued as a Voluntary Plan of Correction in June 2012 after the Resident Quality Inspection.

Throughout the RQI, the following infection control risks were observed:

On May 21, 2014 in a shared tub room the following items were observed not to be labelled with a resident's name. The Primary Care Partner confirmed that the items were shared items and used for the residents of the second floor.
2 containers of zinc ointment
1 bottle of Nizoral shampoo
5 bottles of cologne
2 sticks of deodorant
1 tube of toothpaste

On May 22, 2014 the following was observed:
A soiled basket on the counter top that contained a toothbrush that was in contact with a used applicator for a rectal ointment in a shared bathroom. [s. 229. (4)]

2. The following unlabelled items were observed in a sampling of the residents' shared bathrooms:

8 hairbrushes

4 denture brushes
5 toothbrushes
4 tubes of toothpaste
2 deodorant
9 bottles of lotion
3 combs
1 set of dentures
1 nail clippers
1 urinal
1 razor
Numerous bars of soap

Other infection control concerns:

Soiled washcloths on the chair rail in the hallway and in resident bathrooms.
Visibly soiled k-basins in 5 resident bathrooms.
Commode seat on floor beside commode.
Tub brush on the floor under the tub and bath pillow on floor.

The Registered Practical Nurse confirmed that it is the home's expectation that each resident has their own hygiene and personal care items and that those items belonging to each resident should be labelled with the resident's name. The Registered Practical Nurse confirmed that sharing the hygiene and personal care items between the residents is not in keeping with the home's infection prevention and control policies and practices. (515)(523) [s. 229. (4)]

3. On May 13, 2014, a poster was observed on resident lounge refrigerators on 1st, 2nd and 3rd floors which stated: "Please note that all food that is stored in this refrigerator should be covered appropriately and labelled with a resident's name and date." The following unlabelled and undated items were observed in the resident's lounge refrigerators:
Meringue pie
Tuna salad (3)
Egg salad
Potato salad (2)
Apple juice and orange juice (4)
Chocolate milk, which was missing the lid
Milk (3)
Yoghurt that had an expiry date of February, 2014.

Smoothie
Chicken and chicken nuggets
Partially eaten cheese sandwich
These items were confirmed unlabelled and undated by Primary Care Partners.
The Resident Care Coordinator acknowledged that the unlabelled and undated food and drinks in the resident's lounge refrigerators were not in keeping with the Infection Prevention and Control program. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the annual evaluation of the staffing plan, including the date of the evaluation and the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. This same finding was issued as a Voluntary Plan of Correction during the Resident Quality Inspection in June, 2012.

8/14 (57%) of residents/family answered negatively when asked the question "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time".

Through record review it was revealed that the home does not have a written record of the annual evaluation of the staffing plan. This was confirmed by the Resident Care Coordinator. [s. 31. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had an Administrator who worked regularly in that position, on site at the home, for at least 35 hours per week.

There is one full-time Administrator (Director) for Mount Hope Centre for Long Term Care, which encompasses two long-term care homes; Marian Villa and St. Mary's.

St Mary's has a capacity for 177 residents and Marian Villa has a capacity for 217 residents. Although there is some administrative support from a St Joseph's Health Care, London Vice-President and a number of other St. Joseph's employees, there is not another 35 hours per week on site in the home, in the position of Administrator.

Therefore, Marian Villa does not have an Administrator (Director) who works regularly in that position on site in the home for at least 35 hours per week.

This was confirmed by the Vice-President of Complex, Specialty Aging and Rehabilitative Care. [s. 212. (1) 3.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity was fully respected and promoted.

During the course of the inspection comments were heard from residents and families regarding the residents not being treated with courtesy and respect at all times.

The Coordinator of Resident Care and the Vice-President of Complex, Speciality Aging and Rehabilitative Care confirmed their expectation that all residents are treated with respect and dignity at all times by staff and that there should be no fear of retaliation when residents or family members express concerns about their care. (504) (523) [s. 3. (1) 1.]

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 the resident's right to be treated with courtesy and respect is fully respected and promoted, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The MDS assessment for an identified resident revealed that the resident has impaired vision and does not wear glasses. The Care Plan for the resident revealed the resident wears eye glasses. It is documented in the care plan to "ensure eyewear is clean, appropriate and being worn by resident during activities throughout the day."

The resident does not wear glasses therefore the plan of care does not set out clear direction to staff. This was confirmed by the Registered Practical Nurse. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

An identified resident was noted to be in bed in the afternoon. The resident did not have a falls safety device in place while in bed. A PCP confirmed this device was not being used and indicated it was recently discontinued. The PCP also confirmed the current care plan and kardex showed this device should be used.

Two Registered staff on May 21, 2014 confirmed the resident was assessed as needing this device and that the care plan should be followed. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Observation of care provision revealed a resident preferred to be settled into bed at a particular time of night.

A review of the resident's care plan documentation revealed the resident likes to have the bedtime routine started between one to two hours later than the requested time observed.

A Primary Care Provider confirmed the resident's bedtime routine changes frequently at the request of the resident and sometimes the resident asks to be settled in bed earlier than the care plan indicates.

A Regulated staff member confirmed the resident's care needs changed and the plan of care was not revised at that time. The Coordinator of Resident Care confirmed the home's expectation that the plan of care will be reviewed and revised at least every six months and at any other time when the resident's care needs change. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

An identified resident sustained an injury affecting the ability to perform personal care. The intervention documented in the resident's care plan was staff were to encourage the resident to perform care themselves. The resident reported that staff did not provide assistance to meet the new needs.

The care plan was not revised when the resident's care needs changed. This was confirmed by the Registered Practical Nurse. [s. 6. (10) (b)]

5. The licensee failed to ensure different approaches had been considered in the revision of the care plan when care set out in the plan had not been effective.

A review of the medical record for an identified resident revealed the resident's recent weight was 4.3 kg less than the goal weight noted in the nutrition care plan. There were no new interventions documented for this resident to address the fact that the resident was below the goal weight and had been slowly losing weight.

The Registered Dietitian confirmed there were no new interventions for this resident regarding weight gain or maintenance and that the goal in the care plan would be reviewed. [s. 6. (11) (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 the plan of care provides clear direction, care is provided as set out in the plan of care, assessments are completed when care needs change and if goals are not met other approaches have been considered, to be implemented voluntarily.

WN #8: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the Policy and Procedure dated February 2014 entitled Administration of Medications/Treatments - The "Med Pass" states:

Policy : The nurse responsible for medication/treatment administration must follow established procedures to ensure accuracy of medications administered, resident safety, and efficiency.

Procedure #5: Medications and/or treatments are normally administered in one of two locations - the resident's room, or the unit dining room. Regardless of this, the nurse must ensure that injections, inhalers, and treatments such as eye drops and skin preparations are administered in the resident's room or some other private area, NOT the dining room.

A registered staff person was observed to give three residents treatments in the dining room.

The Coordinator of Resident Care confirmed that these treatments are not to be given in the dining room and the expectation that staff comply with the policy and procedure. [s. 8. (1)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Abuse and Neglect of Residents: Zero Tolerance policy, revised April 2014, included a procedure instructing the person who becomes aware of alleged, witnessed or suspected abuse of a resident must report the incident immediately to the RN, who will in turn notify the Coordinator so they can inform the Ministry.

A review of the progress notes for an identified resident revealed a suspicion of abuse of the resident by family.

There were no critical incident reports filed that day in the Critical Incident System. The progress note was reviewed with the Coordinator of Resident Care who was unaware of this incident. The Coordinator confirmed the expectation that suspected abuse be reported immediately as per the home's policy. [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 the policy regarding Administration of Medications is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On May 13, 2014, at 1045, a Soiled Utility room and Servery were observed to be unlocked and accessible to residents.

A Registered Practical Nurse and Primary Care Partner confirmed the doors were unlocked and the expectation that the doors are to be locked. [s. 9. (1) 2.]

2. The licensee failed to ensure that a door leading to a non-residential area was locked when not being supervised by staff.

On May 13, 2014 the door at the end of the 1st floor hallway which leads to the link between the home and a separate building was observed by two Inspectors to be unlocked. The door was not being supervised by staff. A sign was posted on the door which stated: "Ensure this door is locked at all times." This was confirmed by the Registered Practical Nurse. [s. 9. (1) 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 all door leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Throughout the RQI, an identified resident was observed to have side rails up when in bed.

Documentation in the care plan states the resident is at risk for falls and a safety intervention is to ensure that side rails are up when the resident is in bed.

A review of the resident's health record revealed the bed system for this resident was not evaluated to minimize risk to the resident.

A Registered staff member confirmed an assessment of the bed system was not done. [s. 15. (1) (a)]

2. The licensee failed to ensure where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all zones of entrapment.

Another identified resident had a bed entrapment assessment completed that showed entrapment risks in zones 1, 2 and 4 and this was confirmed by the Resident Care Coordinator. The Resident Care Coordinator confirmed that the resident's care plan does not specify interventions to minimize entrapment risk to the resident. Two Resident Care Coordinators confirmed that no adjustments had been made to the resident's bed post-entrapment assessment to minimize risk to the resident and that the Primary Care Partners had not been educated on the risk to the resident of bed entrapment. This was confirmed by the Registered Practical Nurse. [s. 15. (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 when bed rails are used the resident is assessed and the bed system evaluated to minimize risk, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Call bells were observed to be laying on the floor under the bed in two resident's rooms.

A Primary Care Partner confirmed the call bells were on the floor and not accessible for use by the residents.

An interview with the Coordinator of Resident Care confirmed the call bells are to be within reach and accessible to residents. [s. 17. (1) (a)]

2. A call bell was observed tucked in behind the TV table, out of reach from the bed or the chair in a resident's room. This was confirmed by the Registered Nurse.

Registered Nurses confirmed that it is the home's expectation to have call bell within the reach of residents or visitors. [s. 17. (1) (a)]

3. The licensee failed to ensure the home was equipped with a resident-staff communication and response system that is on at all times.

A call bell button in a resident's room, when pushed, did not activate the light or alarm system.

Staff confirmed the call bell was not functioning and reported it to be fixed. [s. 17. (1) (b)]

4. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents as evidenced by:

It was observed that there was no resident-staff activation system in Room Y008 - Resident Lounge, Room Z001 - Men's washroom and Room Z002 - Women's washroom.

Throughout the RQI residents were observed to be using these areas unsupervised. [s. 17. (1) (e)]

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 the communication and response system can be easily accessed by residents, staff and visitors at all times and is on at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

a) During lunch meal service in the 5th and 3rd floor dining rooms of Marian Villa the temperature was measured at 21 C on 5th floor and 20 C on 3rd floor. The RPNs on each floor noted the temperature and confirmed the process was to call Physical Plant if they had a concern about the temperature being too hot or cold. (171)

b) On May 20, 2014 between 1600 and 1830, Marian Villa 5th Floor hallway, dining room and resident lounge were noticeably cool. Many residents observed to be covered with shawls, sweaters and blankets.

On May 20, 2014 at 1730, the thermostat temperature in the resident lounge read 18.7 degrees Celsius. At 1745 the thermostat temperature read 18.8 degrees Celsius. The thermostat readings were confirmed by Registered staff. (515)

c) A tour of the home on May 21, 2014 with Facilities Engineering Coordinator revealed that the temperature on the first floor hallway by room Y100 was 20 degrees Celsius.

It was confirmed with Facilities Engineering Coordinator that there was no procedure in place to check the home's temperature to ensure it is maintained at a minimum of 22 degrees Celsius. He stated that they would rely on the staff to report if any room or area in the home was too cold or too warm. He agreed that this was not the ideal way of monitoring temperature as it depended on the staff comfort levels.

The Coordinator of Resident Care confirmed the expectation that the temperature in the home will be maintained at a minimum of 22 degrees Celsius. [s. 21.]

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 the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of mood and behaviour patterns, including responsive behaviours.

An identified resident had known responsive behaviours as identified in the MDS Mood and Behaviour assessments dated. The resident did not have a plan of care that addressed responsive behaviours with goals and interventions. A current care plan was not found for the resident in the Point Click Care computer system. The most current nursing care plan, dated March, 2011 was found in the archives by the Registered Practical Nurse.

The Registered Nurse and the Registered Practical Nurse confirmed there was not a current care plan in Point Click Care and the expectation that all residents have a current and updated care plan including goals and interventions. [s. 26. (3) 5.]

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 the plan of care is based on an interdisciplinary assessment of mood and behaviour problems, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to offer the resident an annual dental assessment and other preventive dental services.

During an interview a resident complained of oral pain. The resident's complaint of oral pain was documented in the health record. Through record review it was revealed that the resident had not been offered a dental assessment or other preventive dental services since admission. This was confirmed by the Registered Nurse.

Through an interview with the Coordinator of Resident Care it was confirmed that the home does not have a process in place to offer the residents an annual dental assessment and other preventive dental services. [s. 34. (1) (c)]

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 residents are offered annual dental assessments, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

Two PCPs were observed standing to assist residents who required total assistance with their snack.

Staff indicated that they ensured they were at eye level when assisting residents with feeding while in the dining room, however, they did not always do so while assisting with snacks.

The Coordinator of Resident Care and the Registered Dietitian confirmed the expectation that staff are to be at eye level with the resident when assisting residents with eating at both meals and snacks. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Resident Council in developing and carrying out the satisfaction survey.

An interview with the Resident Council Co-chair on May 15, 2014 revealed that the Home had not sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

An interview with the staff liaison to the Council on May 16, 2014 confirmed the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The Licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

In an interview with the Family Council President, it was confirmed that the licensee had not sought the involvement and advice of the Family Council in developing and carrying out the survey. [s. 85. (3)]

3. The Acting Director/Vice-President of Complex, Speciality Aging and Rehabilitative Care confirmed the home did not seek the advice of the Councils in developing and carrying out the survey. [s. 85. (3)]

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 advice is sought from the Residents' and Family Councils in developing and carrying out the satisfaction survey, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that hazardous substances were kept inaccessible to residents at all times.

A tub room door was observed to be propped open. No staff were in the tub room and no staff were observed in the hallway outside of the tub room for 11 minutes. In the tub room, two bottles of Arjo Disinfectant and one spray bottle labelled Arjo Disinfectant were observed on an open shelf accessible to residents.

This was confirmed by the Occupational Therapist and by a Primary Care Partner. [s. 91.]

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 hazardous substances are inaccessible to residents at all times, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

Four individually wrapped packets of cheese were found in the 5th floor medication refrigerator.

Two Registered staff confirmed the cheese was in the refrigerator.

The Coordinator of Resident Care confirmed the home's expectation that drugs are to be stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. The Licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

a) A medication cart was observed in the dining room to be unlocked and unattended.

A Registered staff confirmed the medication cart was left unlocked and unattended. (515)

b) Another medication cart was observed to be unlocked and unattended. The following medications were found on top of the cart and accessible to residents: a bottle of Lactulose, Omega 3 capsules, Ferrous Gluconate, and Docusate Sodium.

The Registered Practical Nurse confirmed that it is the home's expectation that the medication cart be locked when unattended. (504)

c) An observation on one resident home area revealed that the medication room door was left open and room was unattended. This was confirmed by Registered staff.

Registered staff confirmed the home's expectation was to have all medication rooms and carts locked when unattended. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area that is used exclusively for drugs and is secured and locked, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

An interview with a registered staff, responsible for the government stock room, revealed that bottles of expired drugs were placed in a biomedical bin and removed from the stock room by housekeeping staff. The drugs were not altered or denatured prior to leaving the stock room.

The Coordinator of Resident Care confirmed that drugs were not altered or denatured prior to their removal from the government stock room, and the home's expectation was that medication was to be destroyed to such an extent that its consumption is rendered impossible or improbable prior to removal from the government stock room. [s. 136. (6)]

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 when a drug is destroyed it is altered or denatured to such an extent that its consumption is rendered impossible, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

The home's policy Abuse and Neglect of Residents: Zero Tolerance: Revised April 2014 was reviewed and was found not to include an explanation of the duty under section 24 to make mandatory reports.

The Vice-President confirmed via e-mail that the Zero Tolerance of Abuse Policy does not make reference to the duty to make mandatory reports. [s. 20. (2) (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident's desired bedtime and rest routines are supported.

A review of an identified resident's plan of care and kardex did not reference a desired bedtime and/or rest routine preference.

This was confirmed in an interview with a registered staff member and the Coordinator of Resident Care.

In an interview with the Coordinator of Resident Care it was confirmed that the home's expectation is to have personalized care plans that would reflect resident's preferences regarding desired bedtimes. [s. 41.]

Issued on this 5 day of August 2015 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DONNA TIERNEY (569) - (A4)

Inspection No. / No de l'inspection : 2014_242171_0007 (A4)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000485-14 (A4)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 05, 2015;(A4)

Licensee / Titulaire de permis :

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2

LTC Home / Foyer de SLD :

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - MARIAN VILLA
200 COLLEGE AVENUE, P.O. BOX 5777, LONDON, ON, N6A-1Y1

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janet Groen

---

To ST. JOSEPH'S HEALTH CARE, LONDON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The Licensee shall ensure the home, furnishings and equipment are kept clean and sanitary.

The licensee shall clean and maintain the cleanliness of the ceiling light fixtures and air vents and address the areas that consistently have a bad odour.

Grounds / Motifs :

1. The Licensee failed to ensure that the Home was kept clean and sanitary. This same finding was issued as a Voluntary Plan of Correction on June 20, 2013 after a Complaint Inspection and June 6, 2012 after a Resident Quality Inspection.

On May 13, 2014 at 1000 a tour and observations in the home revealed the

following:
- The armchair beside the elevator doors was visibly soiled on 1st floor
- Air vents were very dusty in 1st floor dining room
- Ceiling vent was visibly thick with dust in the 5th floor tubroom
- Air vent above toilet was visibly dusty in resident bathroom
- Air vents mounted on the counter behind a sink and two under the counter vents were visibly dusty and rusted in the 4th floor lounge
- Dead bugs were observed in the ceiling lights in the 4th floor lounge and 5th floor resident bathroom
- Underneath peeled wallpaper were 2 crawling insects in the 2nd floor dining room

Observations made during Stage 1 of the inspection included:
- dead bugs in the ceiling lights above resident's beds and in resident's bathrooms
- ceiling vent in bathroom visibly thick with dust
- spills on radiator in the 4th floor lounge
- odour in 4th floor lounge

On May 20, 2014 at 1100, a tour and observations in the home with the Environmental Services Coordinator revealed:

- numerous dead bugs in the ceiling light fixtures in hallways and resident's rooms in various locations throughout the home
- stained ceiling tiles in various areas throughout the home
- a bad odour in some areas
- air vents very dusty in numerous areas of the home

In an interview with Environmental Services, it was confirmed that this is a limited listing of the concerns that were found during the tour and observations.

The Environmental Services Coordinator confirmed the expectation is that all home areas and resident rooms are kept clean and sanitary. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The license shall ensure that there are schedules in place for routine, preventative and remedial maintenance in the home that will address the issues as noted in the grounds.

Grounds / Motifs :

1. On May 13, 2014 at 1000 a tour and observations in the home revealed the following:
- Hallways had many areas of paint and plaster peeling and doors scraped on 1st floor
- Chipped paint on walls and stained ceiling tiles in family dining room on 1st floor
- Paint chips below chair rail and between elevator doors and across from nurses station on 2nd floor
- Paint scraped below chair rails and gouged between elevator doors and across from nurses station on 3rd floor

- Plaster missing above radiator, paint chipping above baseboard on wall and end of room, baseboard broken and pulled away from wall at servery in dining room on 4th floor
- Paint peeling on the wall beside the television and unpainted under windows and behind arm chair, and radiator paint peeling off in resident lounge on 4th floor
- The bottom shelf had peeling metal and rust in a shared bathroom cabinet. Soap holder beside the sink was loose and pulled away from the wall, grab bar behind toilet was corroded.

Multiple examples of chipped, scraped and gouged walls, doors and door frames in resident's rooms on all floors of the home.

On May 20, a home tour and observation with the Facilities Engineering Coordinator revealed:

- Ground floor – the baseboard on the wall between the elevators was peeling off.
- 2nd floor- Z215 Bathing Suite - door frame scraped and chipped, paint peeling off the ceiling and hole in the ceiling.
- 2nd floor- wall damage on the wall in hallway, a hole in the drywall, paint scraped off door frame.
- 3rd floor - Z315 Bathing Suite - plastic siding of door frame was off and scrapes on walls
- 5th floor- numerous locations: plastic protection on wall corners were broken.
- 5th floor- scrapes on walls, doors and door frames.

The home tour and observation with the Facilities Engineering Coordinator confirmed wall, baseboard, door and ceiling damage in many resident home areas.

In an interview with Facilities Engineering Coordinator it was confirmed that this is a limited listing of the items that are in need of repair and that numerous other examples had been noted by the inspectors during the course of this inspection. It was confirmed that this list of items is reflective of a lack of routine, preventative and remedial maintenance.

On May 20, 2014 a review of the preventative maintenance program with the Facilities Engineering Coordinator revealed that the home does not have policies and procedures as part of the preventative maintenance program. This was also confirmed by Facilities Engineering Director. (523)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2014

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall ensure:

a) each resident has their own hygiene and personal care items and that those items belonging to each resident are labelled with the resident's name.

b) food and beverage items in the refrigerators are labelled and dated and discarded if past the expiration dates.

Grounds / Motifs :

1. The licensee failed to ensure that the staff participated in the implementation of the infection prevention and control program.
This same finding was issued as a Voluntary Plan of Correction in June 2012 after the Resident Quality Inspection.

Throughout the RQI, the following infection control risks were observed:

On May 21, 2014 in a shared tub room the following items were observed not to be labelled with a resident's name. The Primary Care Partner confirmed that the items were shared items and used for the residents of the second floor.
2 containers of zinc ointment
1 bottle of Nizoral shampoo
5 bottles of cologne
2 sticks of deodorant
1 tube of toothpaste

On May 22, 2014 the following was observed:
A soiled basket on the counter top that contained a toothbrush that was in contact with a used applicator for a rectal ointment in a shared bathroom. [s. 229. (4)] (504A)

2. The following unlabelled items were observed in a sampling of the residents' shared bathrooms:

8 hairbrushes
4 denture brushes
5 toothbrushes
4 tubes of toothpaste
2 deodorant
9 bottles of lotion
3 combs
1 set of dentures
1 nail clippers
1 urinal
1 razor
Numerous bars of soap

Other infection control concerns:

Soiled washcloths on the chair rail in the hallway and in resident bathrooms.
Visibly soiled k-basins in 5 resident bathrooms.
Commode seat on floor beside commode.
Tub brush on the floor under the tub and bath pillow on floor.

The Registered Practical Nurse confirmed that it is the home's expectation that each resident has their own hygiene and personal care items and that those items belonging to each resident should be labelled with the resident's name. The Registered Practical Nurse confirmed that sharing the hygiene and personal care items between the residents is not in keeping with the home's infection prevention and control policies and practices. (515)(523) [s. 229. (4)] (504A)

3. On May 13, 2014, a poster was observed on resident lounge refrigerators on 1st, 2nd and 3rd floors which stated: "Please note that all food that is stored in this refrigerator should be covered appropriately and labelled with a resident's name and date." The following unlabelled and undated items were observed in the resident's lounge refrigerators:
Meringue pie
Tuna salad (3)
Egg salad
Potato salad (2)
Apple juice and orange juice (4)
Chocolate milk, which was missing the lid
Milk (3)
Yogurt that had an expiry date of February, 2014.
Smoothie
Chicken and chicken nuggets
Partially eaten cheese sandwich

These items were confirmed unlabelled and undated by Primary Care Partners.

The Resident Care Coordinator acknowledged that the unlabelled and undated food and drinks in the resident's lounge refrigerators were not in keeping with the Infection Prevention and Control program. (504A)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Order / Ordre :

The licensee will evaluate the current staffing plan and create a written record that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented.

Grounds / Motifs :

1. The licensee failed to ensure that a written record was kept of the annual evaluation of the staffing plan, including the date of the evaluation and the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. This same finding was issued as a Voluntary Plan of Correction during the Resident Quality Inspection in June, 2012.

8/14 (57%) of residents/family answered negatively when asked the question "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time".

Through record review it was revealed that the home does not have a written record of the annual evaluation of the staffing plan. This was confirmed by the Resident Care Coordinator. (504A)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2014

Order # /
Ordre no : 005

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee must ensure that Marian Villa has an Administrator who works regularly in that position, on site at the home,for at least 35 hours per week.

Grounds / Motifs :

1. The licensee failed to ensure that the home had an Administrator who worked regularly in that
position, on site at the home, for at least 35 hours per week.

There is one full-time Administrator (Director) for Mount Hope Centre for Long Term Care, which encompasses two long-term care homes; Marian Villa and St. Mary's.

St. Mary's has a capacity for 177 residents and Marian Villa has a capacity for 217 residents.
Although there is some administrative support from a St Joseph's Health Care, London Vice-President and a number of other St. Joseph's employees, there is not another 35 hours per week on site in the home, in the position of Administrator.

Therefore, Marian Villa does not have an Administrator (Director) who works regularly in that position on site in the home for at least 35 hours per week.

This was confirmed by the Vice-President of Complex, Specialty Aging and Rehabilitative Care. (171)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jan 01, 2016(A4)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5 day of August 2015 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DONNA TIERNEY - (A4)

Service Area Office /
Bureau régional de services : London