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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2014	2014_183135_0027	L-000179-14	Complaint

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 22, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Coordinator of Resident Care, Registered Practical Nurse and 2 Personal Care Providers.

During the course of the inspection, the inspector(s) reviewed resident clinical records and policy and procedures for Skin and Wound and Nutrition and Hydration. Observed resident care and services provided in resident home area.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Reporting and Complaints
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. 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 when the following occurred:

Resident #01 at high nutritional risk for inadequate fluid intake had a nutritional plan of care stating the following:

Refer to the Dietitian (RD) if fluid intake is below 700 mls. for 3 days.

Record review revealed there was no evidence a referral was made to the RD when resident's fluid intake was below 700 mls. for 3 days.

During an interview the Coordinator of Resident Care confirmed her expectation that care set out in the plan of care is provided to the resident as specified in the plan of care related to referrals to the RD when resident's intake is below their assessed requirement. [s. 6. (7)]

2. The Licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed when the following occurred:

Resident #01 was observed by staff as being increasingly lethargic and resident's intake had been poor.

Record review revealed the physician was not notified of the resident's significant change in condition.

During an interview the Coordinator of Resident Care confirmed her expectation that residents are reassessed and the plan of care reviewed and revised when the resident's care needs change. [s. 6. (10) (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 ensuring that the care set out in the plan of care is provided to the resident as specified and residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 when the following occurred:

The home's Skin Care and Assessment and Wound Management Policy revised February 2011 states:

All residents will receive a head- to- toe skin assessment performed by the RN or RPN:

• any time there is a significant change in health status
• the head- to- toe skin assessment is documented in the electronic documentation system using the Head to Toe skin assessment tool.

Resident #01 experienced a significant change in health status and was noted to be increasingly lethargic and experiencing general physical decline.

The resident was assessed as having a new wound.

Record review revealed the resident did not have a head- to- toe skin assessment nor was there any documentation in the home's electronic documentation system using the Head to Toe skin assessment tool as per the home's policy.

During an interview the Coordinator of Resident Care confirmed her expectation that the home's Skin Care and Assessment and Wound Management Policy is complied with when there is significant change in the resident's health status. [s. 8. (1) (a),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 ensuring that the home's Skin Care and Assessment and Wound Management Policy is complied with when there is significant change in the resident's health status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Record review revealed there was no documented evidence resident #01 with wounds, who was dependent on staff for repositioning was repositioned every two hours when the following occurred:

Resident was repositioned 2 to 4 times in documented 24 hour periods.

Resident was assessed as having a new wound.

During an interview the Coordinator of Resident Care confirmed that the resident was not repositioned every two hours and it was her expectation that residents who are dependent on staff for repositioning are repositioned every two hours or more frequently as required. [s. 50. (2) (d)]

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 ensuring that the residents who are dependent on staff for repositioning are repositioned every two hours or more frequently as required depending on the resident's condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that drugs were administered in accordance with the directions for use specified by the prescriber when the following occurred :

Record review revealed there was no documented evidence resident #01 was administered their prescribed medication as follows:

On four occasions medications were not administered as prescribed.

During an interview the Coordinator of Resident Care confirmed the medications were not administered as specified and it was her expectation that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 ensuring that drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that any written complaint that has been received concerning the care of a resident was immediately forwarded to the Director when the following occurred:

The home received a letter of complaint from the family of resident #01.

During an interview the Coordinator of Resident Care confirmed the MOHLTC Director had not been notified immediately of the written complaint.[s. 22. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that a written complaint made to the Licensee concerning the care of a resident was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint when the following occurred.

The family of resident #01 sent a letter of complaint to the home related to the resident's care.

During an interview the Coordinator of Resident Care confirmed the letter had not been responded to within 10 business days. 13, 2014. [s. 101. (1) 1.]

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Issued on this 5th day of May, 2014

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

Bonnie Mac Donald