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
Feb 19, 2014	2014_183135_0001	L-000833-13	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 - 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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29, 2014.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Resident Care Coordinator, Registered Nurse, Registered Practical Nurse, Behaviourial Supports Ontario Team Lead and Personal Care Provider.

During the course of the inspection, the inspector(s) reviewed residents clinical records, critical incident investigation and policies and procedures for Responsive Behaviours. Observation of residents took place on resident home area.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 failed to ensure for each resident that demonstrates responsive behaviours that the behaviour triggers for the resident are identified when the following occurred:

In 2013, resident #02 was physically attacked by resident #01 and was injured.

Record review January 29, 2014, revealed that resident #01 had been experiencing increasing aggressive behaviours towards other residents and staff.
During an interview January 29, 2014, a staff member stated she was unaware of any interventions to deal with resident's aggressive behaviours.

During an interview the Behaviourial Supports Ontario(BSO) Team Lead agreed the resident's behaviourial triggers had not been identified in the plan of care and it was her expectation that residents that demonstrates responsive behaviours have their triggers identified in the plan of care. [s. 53. (4) (a)]

2. The Licensee failed to ensure for each resident that demonstrates responsive behaviours that strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible when the following occurred:

Record review revealed that resident #01, had been experiencing increasing aggressive behaviours towards other residents and staff.

In 2013, resident #02 was physically attacked by resident #01 and was injured.

The following interventions were recommended by the home's BSO Team Lead to deal with resident's aggressive behaviours:

- Repeat pain assessment in dementia and trial giving PRN analgesics
- DOS chart x 4 days
- Request social history assessment from Social Worker
- Monitor closely for signs of increased agitation
- Trial PRN seroquel to decrease sundowning

In a record review January 29, 2014, with the BSO Team Lead it was confirmed that the only intervention that had been implemented was the trial of seroquel to decrease sundowing.

During an interview the BSO Team Lead confirmed her expectation that residents that demonstrates responsive behaviours have strategies implemented in response to the resident's responsive behaviours. [s. 53. (4) (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 for each resident that demonstrates responsive behaviours that the behaviour triggers are identified and strategies are developed and implemented for the resident, to be implemented voluntarily.

Issued on this 19th day of February, 2014

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

Bonnie MacDonald