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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_536537_0039	011876-16, 017192-16, 017196-16, 017310-16, 020653-16, 022494-16, 025498-16, 027666-16, 029472-16, 029822-16, 029827-16, 029947-16, 030213-16, 030318-16, 030368-16, 030865-16, 030866-16, 031968-16, 031971-16, 032679-16, 034738-16, 035400-16, 000060-17, 001872-17, 006140-17, 007409-17, 008052-17, 009550-17, 009800-17, 009938-17, 010049-17, 013891-17, 014676-17, 014800-17, 016359-17, 019128-17, 021282-17	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

Mount Hope Centre for Long Term Care
21 GROSVENOR STREET P.O. BOX 5777 LONDON ON N6A 1Y6

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

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630), INA REYNOLDS (524), NEIL KIKUTA (658)

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): September 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, 27, 28, 29 and October 3, 2017

The following intakes were inspected:
Related to the Allegations of Staff to Resident Abuse:
Log # 017192-16/ C596-000038-16
Log #017196-16/ C596-000037-16
Log #029472-16/ C596-000067-16
Log #029827-16/C596-000072-16
Log #030318-16/C596-000075-16
Log #034738-16/ C596-000007-17
Log #007409-17/ C596-000046-17
Log #010049-17/ C596-000060-17
Log #014800-17/ C596-000070-17
Log #016359-17/ C596-000070-17
Log #019128-17/ C596-000086-17
Log #021282-17/C596-000093-17

Related to the Allegations of Resident to Resident Abuse:
Log #029822-16/ C596-000071-16
Log #030368-16/C596-000074-16
Log #030866-16/ C596-000079-16
Log #031968-16/ C596-000087-16
Log #031971-16/ C596-000086-16
Log #000060-17/ C596-000002-17
Log #008052-17/ C596-000049-17
Log #009550-17/ C596-000050-17
Log #009938-17/ C596-000059-17

Log #014676-17/ C596-000071-17

Related to Missing Residents:
Log #011876-16 / C596-000026-16
Log #006140-17/ C596-000036-17

Related to Injury that Results in Transfer to Hospital and which results in a Significant Change in Status:
Log #017310-16/ C596-000024-16
Log #022494-16/ C596-000044-16
Log #025498-16/ C596-000052-16
Log #029947-16/ C596-000073-16
Log #030213-16/ C596-000048-16
Log #030865-16–/C596-000077-16
Log #032679-16/ C596-000090-16
Log #001872-17/ C596-000014-17
Log #009800-17/ C596-000058-17

Related to a Medication Incident/Adverse Drug Reaction:
Log #035400-16/ C596-000115-16

Related to Missing/Unaccounted for Controlled Substances:
Log #027666-16/ C596-000055-16
Log #013891-17/ C596-000078-17

Related to Entrapment:
Log #020653-16/ C596-000043-16

A Written Notification related to O. Reg. 79/10, s.107.(3) 1, identified in concurrent inspection #2017_536537_0037 will be issued in this report.
A Written Notification under O.Reg. 79/10, s. 20, identified in this inspection will be issued under a Complaint Inspection #2017_536537_0037 concurrently inspected during this inspection.
A Written Notification (WN) and Compliance Order (CO) under O. Reg 79/10, s. 6.(7), identified in this inspection will be issued under a Follow Up Inspection #2017_536537_0035 concurrently inspected during this inspection.

A Written Notification (WN) and Voluntary Plan of Correction (VPC) under O. Reg 79/10, s.8 (1) (b), identified in this inspection will be issued under a Complaint Inspection 2017_536537_0037 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Directors, Coordinator St Mary's (SM), Coordinator Marian Villa (MV), Point Click Care (PCC) Support, Administrative Assistant, Quality Project Lead, Director of Facilities Management (DOFM), Assistant Coordinator of Care St Mary's, Assistant Coordinator Marian Villa, Registered Dietitian (RD), Coordinator Dietary, Manager Resident Services Sienna, Resident Assessment Instrument (RAI) Consultant, Human Resources Manager Medical Priorities, Coordinator Medical Priorities, Staff Educator, Scheduling Lead, Privacy Consultant St. Josephs, Detective London Police Services, Pharmacist, Bellwright, five Registered Nurses (RN), 16 Registered Practical Nurses (RPN), 34 Personal Care Providers (PCP), one Personal Care Assistant (PCA), one Housekeeping Aide, one Dietary Aide, one Therapeutic Recreation Aide, families and residents.

The inspector(s) also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed assessments, various policies and procedures of the home, training records and the home's internal plans, reviewed various meeting minutes, and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
2 VPC(s)
0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on the needs and preferences of the resident in regards to continence care.

A Critical Incident System (CIS) report was submitted by the home regarding concerns raised by a resident about toileting and continence care.

The identified resident told Inspector #630 that their needs and preferences were not being considered in the plan of care.

A Personal Care Provider (PCP) said that if they needed to know specific care routines regarding continence care and toileting needs of a resident they would look in the plan of care and the Kardex.

A Registered Practical Nurse (RPN) stated there had been a recent change in condition of the resident resulting in changes to the plan of care related to toileting and continence care.

Review of the clinical record for the resident included several progress notes involving the resident, family and the staff of the home to develop a plan that would be acceptable to all involved.

The plan or care for the resident included several interventions related to toileting.

Coordinator MV shared as follow-up to the CIS investigation, they were working with the resident and their family to develop the plan of care for continence care and toileting to better meet their needs and preferences. Coordinator MV said the resident was frequently changing their mind about what they agreed to in regards to toileting and

continence care. Coordinator MV acknowledged that the plan of care identified a routine that was different than the expressed preferences of the resident. Coordinator MV said that if the resident's preference or need was different than that identified in the care plan, then the plan of care should be updated to reflect this preference and need. Coordinator MV acknowledged the current plan of care for the resident did not reflect the preferences or needs regarding toileting and said it needed to be revised to better reflect the resident's needs and preferences.

The severity level was determined to be level two a minimal or actual potential for risk or harm. The scope was determined to be isolated. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2015_326569_0009 as a Voluntary Plan of Correction (VPC), June 9, 2015, in a Complaint Inspection #2105_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR), June 7, 2016, in a Critical Incident Inspection #2016_217137_0014 as a VPC, and December 12, 2016 in a Resident Quality Inspection #2016_457630_0045, as a Director Referral (DR). [s. 6. (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 that the care set out in the plan of care was based on the needs and preferences of the resident, to be implemented voluntarily.

WN #2: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions, including risk of falls.

The admission MV-Falls Risk (Morse) Assessment for an identified resident noted the resident was at high risk for falls.

Review of the clinical record for the resident included falls that the resident had experienced and corresponding post-fall assessments related to the falls.

The plan of care for the resident included a focus statement that identified the resident as a falls risk. There were no strategies or interventions related to risk of falls or falls prevention found in the plan of care despite the falls risk having been identified prior to the actual falls.

The home's policy titled "Falls: Assessment for Falls Risk and Management of Fall Events" revised date April 2017, stated that "Mount Hope staff implement fall prevention strategies for all residents. Additional Measures are implemented for those residents identified as at greater risk for falls from the falls risk assessment".

Coordinator Marian Villa (MV) said the home's expectation was that the plan of care was to include interventions related to falls prevention for residents who were assessed as a high risk for falls. Coordinator MV agreed that the resident was assessed as a high risk for falls and that the plan of care for the resident did not include interventions related to falls prevention.

The severity was determined to be level two as there was minimal harm or potential for actual harm. The scope was isolated. There was a compliance history of this legislation being issued in the home on June 9, 2015 in a Complaint Inspection #2015_183135_0024 as a Voluntary Plan of Correction (VPC), and on January 5, 2016 in a Resident Quality Inspection #2016_254610_0001 as a VPC. [s. 26. (3) 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 that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report, which was made to the Director under subsection 23 (2) of the Act, included in writing a description of the individuals involved in the incident, including the names of any staff members who were present at or discovered the incident.

A Critical Incident System (CIS) report was submitted by the home identifying a potential staff to resident neglect. This report stated that Personal Care Provider (PCP) staff

reported residents in an identified home area on a specific shift were not provided with continence care. This report did not include the names of the staff who were present or who discovered the incident.

Coordinator MV acknowledged to Inspector #630 that the CIS report did not include the names of staff involved in the incident. Coordinator MV said it was the expectation in the home that the CIS report would include all the information required in the legislation. [s. 104. (1) 2.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee made the report within 10 days of becoming aware of the alleged, suspected, or witnessed incident.

Ontario Regulation 79/10, s. 104(1) states in part that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material as outlined in O. Reg. 79/10, s.104 (1) in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

The home contacted the after-hours pager and submitted a SAC incident related to an alleged physical abuse of a resident by a staff member. The associated Critical Incident System (CIS) report that contained in writing the requirements as outlined in O. Reg. 79/10, s. 104(1), was not submitted to the Ministry of Health and Long-Term Care (MOHLTC) within the required time frame.

The Coordinator of Saint Mary's (SM) reviewed the CIS report and explained that the previous Director had thought they had submitted the report, but had only saved it. Coordinator SM said that the expectation was that the CIS report should be reported the next business day.

The severity was determined to be level one as there was minimum risk. The scope was isolated. There was a compliance history of this legislation being issued in the home on October 29, 2015 in a Critical Incident Inspection #2015_326569_0021 as a Written Notice, on May 26, 2016 in a Critical Incident Inspection #2016_226192_0022 and on June 7, 2016 in a Critical Incident Inspection #2016_217137_0014 as a Written Notice. [s. 104. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a resident who was missing from the home for less than three hours and who returned to the home with no injury or adverse change in condition, within one business day, followed by the report required under subsection (4).

A Critical Incident System (CIS) report was submitted by the home following the receipt of a complaint from a family, related to an incident with a resident.

The Coordinator Marian Villa (MV) shared that the home had submitted a CIS report to the MOHLTC based on the family complaint but stated that a Critical Incident System Report had not been submitted to the Director informing of a resident who was missing from the home for less than three hours and who returned to the home with no injury or adverse change in condition, within one business day. [s. 107. (3) 1.]

2. The licensee has failed to ensure that a missing or unaccounted for controlled substance was reported to the Director no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A) Review of Critical Incident System (CIS) report identified missing or unaccounted for controlled substances as prescribed to an identified resident.

Review of the progress notes for the resident showed a Patient Safety Reporting System report documented on four separate occasions identifying the prescribed controlled substance for the resident was not able to be located.

A CIS was submitted to the MOHLTC six days after the last noted date that a Patient Safety Reporting System report was generated. The missing narcotics identified in the initial three Patient Safety Reporting System reports were also included on this CIS.

Coordinator MV stated that a CIS report should have been filed for each incident of missing or unaccounted for controlled substances, and that the CIS report that was submitted was not submitted within one business day as required.

B) Review of a Critical Incident System (CIS) report identified missing or unaccounted for controlled substances for an identified resident.

Coordinator Marian Villa (MV) stated they became aware of the missing controlled substance when drug destruction was being completed by the pharmacist and a Registered Nurse from the home. Coordinator MV was made aware of a missing narcotic according to the narcotic count sheets, and as a result, initiated an internal investigation. Coordinator MV stated they did not initiate the CIS until they finished the investigation and were not able to account for the missing narcotic.

Coordinator Marian Villa (MV) stated that missing or unaccounted for narcotics were to be reported to the Director within one business day of becoming aware of the incident. [s. 107. (3) 3.]

3. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (3), the licensee made a report in writing to the Director setting out the outcome or current status of the individual involved in the incident within 10 days of becoming aware of the incident.

The home submitted a Critical Incident System (CIS) report related to an incident with a resident. The home did not submit an amendment to the CIS report within 10 days. Coordinator SM stated that it was the expectation that the CIS report would be kept current, that the report should be completed within 10 days, and to complete amendments as requested.

The severity was determined to be level one as there was minimum risk. The scope was isolated. There was a compliance history of this legislation being issued in the home on January 5, 2016 in a Resident Quality Inspection #2016_254610_0001 as a Written Notification. [s. 107. (4) 3. v.]

Issued on this 30th day of November, 2017

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

Original report signed by the inspector.