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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2018	2018_263524_0017	015263-18, 017172-18, 027002-18	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

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

INA REYNOLDS (524), AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569), JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15, 16, 17, 18, 19, 22, 24, 25, 26, 29, 30, 31, November 1 and 2, 2018.

The following Follow-up intakes were completed within the Resident Quality Inspection:
Log #015263-18 for Compliance Order (CO) #001 from Follow-up Inspection #2018_729615_0014 related to the monitoring and recording of symptoms of infection in residents on every shift.

Log #017172-18 for Compliance Order (CO) #001 from Critical Incident System Inspection #2018-607523-0014 related to residents receiving the required level of supervision and/or assistance while ambulating as set out in the plan of care.

The following Complaint intakes were completed within the Resident Quality Inspection:
Log #026089-17 related to sufficient staffing
Log #029319-17 / IL-54669-LO related to continence care, supplies and skin and wound care
Log #004437-18 / IL-55790-LO related to personal care, skin and wound care, and laundry service
Log #012017-18 / IL-57265-LO related to allegations of abuse
Log #015195-18 / IL-57554-LO related to responsive behaviours and sufficient staffing
Log #017428-18 / IL-58019-LO related to falls prevention, responsive behaviours, medication management and personal care
Log #019266-18 / IL-58416-LO related to skin and wound care
Log #019885-18 / IL-58607-LO related to allegations of abuse
Log #021533-18 / IL-59070-LO related to medication management, infection prevention and control and skin and wound Care
Log #020490-18 / IL-58812-LO related to skin and wound care
Log #025175-18 / IL-59941-LO related to responsive behaviours
Log #025764-18 / IL-60166-LO related to allegations of abuse.

The following Critical Incidents were completed within the Resident Quality Inspection:
Log #028583-17 / CIS #C596-000125-17 related to the medication management system
Log #029422-17 / CIS #C596-000134-17 related to allegations of abuse
Log #029625-17 / CIS #C596-000138-17 related to allegations of abuse and responsive behaviours
Log #000202-18 / CIS #C596-000001-18 related to falls prevention and management
Log #001324-18 / CIS #C596-000004-18 related to falls prevention and management
Log #002121-18 / CIS #C596-000007-18 related to infection prevention and control
Log #002225-18 / CIS #C596-000009-18 related to plan of care
Log #002445-18 / CIS #C596-000010-18 related to transferring and positioning techniques
Log #003733-18 / CIS #C596-000017-18 related to falls prevention and management

Log #003840-18 / CIS #C596-000016-18 related to allegations of abuse
Log #003900-18 / CIS #C596-000018-18 related to the medication management system
Log #000472-18 / CIS #C596-000025-18 related to allegations of abuse
Log #004913-18 / CIS #C596-000026-18 related to allegations of abuse
Log #006291-18 / CIS #C596-000019-18 related to infection prevention and control
Log #006431-18 / CIS #C596-000037-18 related to allegations of abuse
Log #007257-18 / CIS #C596-000040-18 related to allegations of abuse
Log #007276-18 / CIS #C596-000032-18 related to infection prevention and control
Log #007466-18 / CIS #C596-000035-18 related to infection prevention and control
Log #008047-18 / CIS #C596-000034-18 related to infection prevention and control
Log #010691-18 / CIS #C596-000052-18 related to falls prevention and management
Log #015108-18 / CIS #C596-000061-18 related to infection prevention and control
Log #016364-18 / CIS #C596-000064-18 related to falls prevention and management
Log #017540-18 / CIS #C596-000071-18 related to falls prevention and management
Log #018400-18 / CIS #C596-000073-18 related to falls prevention and management
Log #020165-18 / CIS #C596-000075-18 related to allegations of abuse
Log #022402-18 / CIS #C596-000080-18 related to falls prevention and management
Log #023837-18 / CIS #C596-000082-18 related to infection prevention and control
Log #024422-18 / CIS #C596-000084-18 related to falls prevention and management
Log #025656-18 / CIS #C596-000092-18 related to allegations of abuse
Log #026105-18 / CIS #C596-000097-18 related to allegations of abuse
Log #026472-18 / CIS #C596-000098-18 related to allegations of abuse
Log #026786-18 / CIS #C596-000100-18 related to allegations of abuse
Log #026711-18 / CIS #C596-000102-18 related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Medical Director, the Interim Director of Care, four Associate Directors of Care, the Environmental Services Manager, the Administrative Assistant, the Resident Assessment Instrument Coordinator, the Education Coordinator, six Registered Nurses, eighteen Registered Practical Nurses, fifteen Primary Care Providers, one Dietary Aide, two Housekeepers, one Therapeutic Recreation Assistant, one Physiotherapy Assistant, the Residents' Council Representative, the Family Council Representative, residents and family members.

The inspector(s) also conducted a tour of the home, observed resident care provisions, resident and staff interactions, dining services, medication

administration, a medication storage area, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home. Inspectors reviewed residents' clinical records, postings of required information, relevant meeting minutes, internal investigation notes, medication incident reports, staff education records and relevant policies and procedures of the home.

Inspectors Christy Legouffe (#730) and Kristen Murray (#731) were also present during this inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (5)	CO #001	2018_729615_0014	524
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_607523_0014	524

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	Légende 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. 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 has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with applicable requirements under the Act.

Ontario Regulation 79/10, s. 114(2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg. 79/10, s. 135(1) states that every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home's medication incidents for a specific period of time, noted no documentation to support that the Medical Director of the home had been notified of the medication incidents.

In an interview on a specific date, the Medical Director stated that they were made aware of medication incidents during review of the incidents at the home's quarterly Medication Management System meetings.

Review of St. Joseph's Health Care policy Reporting and Review of Adverse Events

Near Misses/Patient Safety Reporting with a review date of September 11, 2015, noted no reference to notification of the Medical Director and pharmacy of medication incidents.

In an interview on a specific date, the Executive Director reviewed the home's policy with the inspector and confirmed the home's policy did not indicate that the Medical Director and pharmacy were to be notified of medication incidents.

The licensee has failed to ensure that the home's medication management system policies were in compliance with the Act and Regulation. [s. 8. (1) (a)]

2. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care, related to missing medication on a specific date for an identified resident.

A review of St. Joseph's Health Care policy related to the identified medication, noted that the registered staff were to document in the progress notes that the medication was not found.

Review of the resident's progress notes noted no documentation related to the resident's missing medication.

In an interview on a specific date, an Associate Director of Care confirmed the incident related to the resident's missing medication was not documented in the resident's progress notes and should have been.

The licensee has failed to ensure that the home's medication management policy was complied with. [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 that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that mobile equipment was kept clean and sanitary.

On an identified date, during Stage 1 of the RQI, inspectors observed that an identified resident had dried splatter, dirt and debris on their mobile equipment and accessories. On an identified date, an inspector observed that another resident had dried splatter, dirt and debris on their mobile equipment and accessories. It was also observed that a third resident had dried splatter, dirt and debris on their mobile equipment. On a later date, an inspector observed that the three residents still had dried splatter, dirt and debris on their mobile equipment and accessories.

The clinical record for the residents indicated that they used a device for all mobility. The plan of care for each resident included an intervention "device cleaning - staff to ensure"

mobile equipment was cleaned as per schedule. The progress notes identified the dates when the residents mobile device were last cleaned.

On an identified date, a Registered Practical Nurse (RPN) said that they did not think there was a schedule or procedure in place for cleaning resident mobile equipment apart from noting on the shift report if staff noticed that a device needed to be cleaned by staff. The RPN and inspector observed the mobile device for the residents and the RPN said that these devices, including the accessories, were visibly soiled and appeared that they had not been recently cleaned. The RPN and inspector observed the mobile device for an identified resident and the RPN said this device appeared to have been cleaned recently and that was what they would have expected all devices to look like in terms of cleanliness.

On an identified date, an Associate Director of Care (ADOC) said that the home did have a process in place for cleaning all mobile devices. The ADOC said it was the expectation that staff would be wiping any spills using disinfectant wipes at the time that they occurred. The ADOC said that there was also a process for a physiotherapy assistant to clean devices on a regular basis based on a schedule and that this staff member would have documentation regarding the devices that were cleaned. The ADOC said a new company was scheduled to start doing thorough cleaning of identified mobile equipment in the home twice a year and that this was to start the following week. The ADOC provided the policy for cleaning of resident equipment and said that this policy applied to the cleaning of resident's mobile devices. The inspector and ADOC observed pictures of the three resident's mobile devices from the observation date and the ADOC acknowledged they were visibly soiled and dirty. The ADOC said it was the expectation that mobile equipment would be kept clean.

The home's policy titled "Standard Wiping Protocol for Disinfecting Mobile Patient Equipment" with revised date May 25, 2016, stated "routine wiping is required to disinfect the surfaces of mobile non-critical equipment which may become soiled or contaminated with microorganisms after contact with the patient during care or transport." This policy also stated "equipment in these areas should have routine cleaning schedules in place with dedicated accountabilities that meet the citywide environmental cleaning standards and frequencies."

On an identified date, an Occupational Therapy Aide/Physio Therapy Aide (OTA/PTA) said that it was the process in the home that the staff working in the floors would wipe any visible spills or dirt off residents' devices on a daily basis. The OTA/PTA said that

their role was to do a deep clean of each resident's mobile devices in the entire home based on a schedule and that each identified device had a deep clean about every 20 weeks based on this rotation as well as on an as needed basis when they received a referral. The OTA/PTA said that on a specific date, they had started an additional new process for an external company to come into the home and do a deep cleaning of the devices twice per year. The OTA/PTA said they documented in the progress notes when a deep cleaning was done. The OTA/PTA had not been able to do the deep cleaning of the wheelchairs as per the process since July 2018 and they did not think that anyone had taken on that process in the home. The OTA/PTA and inspector reviewed the pictures of residents mobile devices and the OTA/PTA acknowledged they were not clean and that it was the expectation in the home that these mobile devices would be kept clean as per the wipe down by staff daily and the deep cleaning. The OTA/PTA said that they were half time in the role for cleaning the mobile devices and it was difficult to rely on one staff person to do the routine deep cleaning especially if staff were not doing the daily wiping.

On an identified date, the Executive Director (ED) said it was the expectation in the home that mobile devices would be kept clean. The ED said they had identified concerns with the cleanliness of devices particularly for the residents who fed themselves with high soiling. The ED said they put out a reminder to staff regarding the standard wiping protocol and that did not appear to be in place on a daily basis.

Based on observations of the resident's mobility devices, these devices were observed on multiple occasions during the inspection to be unclean. Based on interviews and record reviews these devices had not had a deep clean completed for over three months. Based on interviews it was the expectation that mobile devices would be cleaned regularly using a "standard wiping protocol" and this had not been fully implemented in the home. At the time of the inspection the home's procedures for deep cleaning of mobile devices did not effectively ensure that each resident's device was kept clean and sanitary. [s. 15. (2) (a)]

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 mobile equipment is kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The definition of emotional abuse, in the Long-Term Care Homes Act (LTCH Act) 2007, under s. 2 (1) (a) heading "emotional abuse" stated: (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home on a specific date, related to an allegation of abuse.

The CIS noted that the resident reported on a specific date, that on the previous evening, a Registered Practical Nurse (RPN) restricted their mobility, and left them sitting in their room without a call bell for over two hours.

A review of the home’s investigative notes noted that a PCP was asked by the RPN to restrict their mobility as the resident was not listening and that the RPN had told the resident to go to their room. The PCP stated they were told by the RPN to do so. The PCP stated that the resident had a call bell but because of their mobility restriction they were probably not able to reach it.

In an interview on a specific date, an Associate Director of Care confirmed that the allegations of abuse were substantiated and that a PCP and RPN were terminated due to the incident of abuse. The termination letters to the RPN and PCP were reviewed by the inspector.

The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (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 that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), which was identified as an incident of resident to resident abuse which had occurred on a specific date and reported on a later date.

Review of an identified resident's progress notes in Point Click Care (PCC), stated that

on a specific date the resident reported to staff that another resident attempted to inappropriately touch them, but that they were able to slap their hand away. The note stated that the resident said that this was not the only time the other identified resident had tried to touch them.

Review of the resident's progress notes in PCC, for an earlier date, showed documentation of an Incident/Patient Safety Reporting System (PSRS) note that the Primary Care Provider (PCP) reported another non-consensual touching incident to the identified resident. The note stated that staff advised the other resident that the behaviour was unwanted and was redirected away from the resident. The inspector confirmed that a CIS was not completed by the home or reported to the MOHLTC on that specific date, related to this incident.

During an interview with an Associate Director of Care (ADOC), the ADOC stated that it was mandatory for staff to report any type of abuse, including alleged, witnessed or suspected abuse. The ADOC confirmed that the incident of non-consensual touching to the resident occurred on a specific date. The ADOC stated that the staff should have reported the incident on the day it occurred, however, it was reported to the MOHLTC on a later date. The ADOC stated that the expectation was that the incident of abuse was to be submitted or reported to the after-hours line by the registered staff on duty. The inspector reviewed the CIS report related to this incident, which documented that the resident said that this was not the only time the other resident had tried to inappropriately touch them. When asked if they were aware of other incidents between the residents, the ADOC stated no. The ADOC reviewed the resident's progress note that showed an earlier Incident/PSRS note which documented non-consensual touching to the resident by another resident. The ADOC stated that they would have expected that the allegation of abuse should have been reported to the MOHLTC.

The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (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 that when a person has reasonable grounds to suspect abuse of a resident has occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

As part of the Resident Quality Inspection medication incidents were reviewed for a specific period.

A review of a Medication Incident Event noted that a resident had returned from outside treatment on a specific date, with doctor's orders. The orders had been faxed to the physician but there was no return fax with medication verification received from the physician. All of the resident's previously scheduled medications and two as needed medications were administered to the resident without doctor's orders. There were no adverse effects to the resident.

In an interview on a specific date, an Associate Director of Care confirmed that the resident had been administered medications without a doctor's order.

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

As part of the Resident Quality Inspection medication incidents were reviewed for a specific period of time. The most recent medication incident and two random medication incidents were reviewed.

A) Review of a Medication Incident Event noted that a resident was not given their medication as per doctor's orders.

Review of the resident's electronic medication administration record from a specific period of time, noted their medication was to be administered at specific hours.

In an interview, a Registered Practical Nurse stated they worked part time and relied on the resident's electronic Medication Administration Record (eMAR) to administer medication. The RPN stated that the resident did not have an order to administer the medication earlier on the resident's identified treatment days, and that the order was for administration at a specific hour on the resident's eMAR. The Registered Practical Nurse stated that the eMAR for the resident was not consistent in what time the resident was to receive their medication as the resident received it earlier than the prescribed hours on the identified days due to their specific treatment, but this was not reflected in the order in the eMAR.

In an interview on a specific date, an Associate Director of Care stated the RPN had actually not made a medication error as the doctor's order was for the medication to be administered at a specific hour, but that registered staff were giving the resident their medication earlier on treatment days without an order.

B) Review of a Medication Incident Event noted on a specific date, that a resident was not given their medication at a specific hour, as prescribed by the physician. The medication was signed in the resident's eMAR as given, but the medication were not given as per the medication count.

In an interview, an Associate Director of Care confirmed that the resident had not been administered their medication as prescribed.

The licensee has failed to ensure that drugs were 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 to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident; and, that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care and the resident's attending physician.

As part of the Resident Quality Inspection medication incidents were reviewed for a specific period of time.

A) Review of a Medication Incident Event noted on multiple dates, that a resident was not given their medication at a specific hour, as prescribed by the physician. The medication was signed in the resident's eMAR as given but the medication was not given as per the medication count.

Review of the resident's electronic progress notes and medication incident in the Patient Safety Reporting System (PSRS) noted there was no documented evidence to support that the resident was assessed. There was also no documentation to support that the resident's substitute decision-maker (SDM) was notified.

In an interview on a specific date, an Associate Director of Care confirmed that the resident should have been assessed when it was discovered that they had missed their medication and that this should have been documented. The ADOC also confirmed that the resident's SDM had not been notified.

B) Review of a Medication Incident Event noted that a resident had returned from outside treatment on a specific date, with doctor's orders. The orders had been faxed to the physician but there was no return fax with medication verification received from the physician. All of the resident's previously scheduled shift medications and two as needed medications during another shift were administered by staff without doctor's orders. There were no adverse effects to the resident.

Review of the resident's progress notes and medication incident in PSRS noted there was no documentation related to the immediate action taken to assess the resident's health and notification of the resident's SDM.

In an interview on a specific date, an ADOC confirmed there was no documentation related to the immediate action taken to assess the resident's health and documentation that the resident's substitute decision maker had been notified of the medication incident.

C) Review of a Medication Incident Event noted that an identified resident had missed their dose of medication.

In an interview on a specific date, the resident stated that they had not been made aware of the incident with the administration of their medication.

A review of the resident's electronic progress notes and medication incident in PSRS noted there was no documentation to support that the resident and Director of Care had been notified of the medication incident.

In an interview on a specific date, an ADOC confirmed that there was no documentation to support that the medication incident had been reported to the resident and the Director of Care.

D) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date, related to missing medication for an identified resident. The CIS report indicated that on a specific date and time, the resident's medication could not be found.

Review of the resident's electronic progress notes and medication incident in PSRS Medication Incident Event noted there was no documented evidence to support that the resident had been assessed.

In an interview, an ADOC confirmed that there was no documentation to support that the resident had been assessed and that the resident should have been assessed.

E) The home submitted an identified Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date, related to missing medication for an identified resident. The CIS report indicated that on a specific date and time, the resident's medication could not be located during the resident's medication check.

Review of the resident's electronic progress notes and medication incident in PSRS Medication Incident Event noted there was no documented evidence to support that the resident was assessed. There was also no documentation to support that the medication incident had been reported to the Director of Care (DOC) and the resident's physician.

In an interview on a specific date, an ADOC confirmed that there was no documentation to support that the resident had been assessed and that the resident should have been assessed. The ADOC also stated there was no documentation to support that the DOC and resident's physician had been notified of the missing medication. In an interview, the Executive Director stated the medication incidents should be documented with the immediate actions taken to assess the resident's health. The ED also stated that the medication incidents should be reported to the resident, the resident's SDM, the DOC

and the resident's physician.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was; (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and; (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

As part of the Resident Quality Inspection medication incidents were reviewed for a specific period of time.

A) Review of a Medication Incident Event noted on multiple dates, that a resident was not given their medication at a specific hour, as prescribed by the physician. The medication was signed in the resident's eMAR as given but the medication was not given as per the medication count.

Review of the medication incident in the Patient Safety Reporting System (PSRS) noted there was no documented evidence to support any corrective action that was taken.

In an interview, an Associate Director of Care confirmed they had not documented in PSRS any corrective action that was taken related to the medication incident.

B) Review of a Medication Incident Event noted that a resident had returned from outside treatment on a specific date, with doctor's orders. The orders had been faxed to the physician but there was no return fax with medication verification received from the physician. All of the resident's previously scheduled shift medications and two as needed medications during another shift were administered by staff without doctor's orders. There were no adverse effects to the resident.

Review of the medication incident in PSRS noted there was no documented evidence to support any corrective action that was taken.

In an interview on a specific date, an ADOC confirmed they had not documented in PSRS any corrective action that was taken related to the medication incident.

C) Review of a Medication Incident Event noted that an identified resident had a missed dose of medication.

Review of the medication incident in PSRS noted there was no documented evidence to support any corrective action that was taken.

In an interview on a specific date, an ADOC confirmed they had not documented in PSRS any corrective action that was taken related to the medication incident.

D) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date, related to missing medication for an identified resident.

Review of the medication incident in PSRS Event noted there was no documented evidence to support any corrective action that was taken.

In an interview on a specific date, an ADOC confirmed they had not documented in PSRS any corrective action that was taken related to the medication incident.

E) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date, related to a missing medication for an identified resident.

Review of the medication incident in PSRS Event noted there was no documented evidence to support any corrective action that was taken.

In an interview on a specific dated, an ADOC confirmed they had not documented in PSRS any corrective action that was taken related to the medication incident. In an interview, the Executive Director stated that corrective action related to medication incidents should be documented in PSRS. ED stated medication incidents were reviewed and analyzed quarterly at Medication Management System (MMS) meetings. The ED stated that at the last MMS meeting on March 20, 2018, review and analysis of medication incidents was deferred and the ED was unable to find any documentation related to the review and analysis of medication incidents for 2018.

The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In an interview on November 1, 2018, the Executive Director stated medication incidents were reviewed quarterly at Medication Management System (MMS) meetings. The ED stated that at the last MMS meeting on March 20, 2018, review and analysis of medication incidents was deferred and the ED was unable to find any documentation related to the quarterly review of medication incidents for 2018.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (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 that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care and the resident's attending physician; to ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b); and, to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that has occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #7: 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. (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).

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date, which identified a fall resulting in injury for an identified resident.

A review of the Post Fall Assessment Initial Note in Point Click Care (PCC) for the resident showed documentation that the resident had an unwitnessed fall on a specific date.

The care plan in Point Click Care (PCC) with a specific review date for the resident, stated that the resident required assistance with transfers and use of a transfer device if the resident was fatigued. The care plan for the resident stated that the resident did not walk, would continue to self-propel their own mobile device for locomotion, and that the resident rarely independently self-propelled and required total physical assistance from staff for short or long distances.

In an interview with a Registered Practical Nurse (RPN) on a specific date, the RPN stated that the resident's current mobility status was that they were able to walk and that they required supervision for transfers. The RPN reviewed the most recent care plan and the physiotherapist assessment and confirmed that the care plan was not reflective of the resident's current mobility and transfer status.

During a resident observation on a specific date, inspectors observed a Primary Care Provider (PCP) inform the resident that it was meal time and offered assistance to the dining area. The inspectors observed the resident use their mobility device to stand up from a seated position and walk independently to the dining area with supervision from the PCP.

In an interview with a PCP and RPN on a specific date, the PCP identified the current mobility status for the resident. When asked where staff would identify resident's interventions for mobility and transfer status, the PCP stated they would refer to Point of Care (POC) and the Kardex. The PCP observed the resident's room with the inspectors and identified pictorial signage posted on the wall, which showed the residents current transfer status and mobility aides used. The PCP and RPN reviewed the care plan for the resident and stated that the care plan was not reflective of the resident's current mobility/transfer status and pictorial signage. The PCP stated that the care plan showed old interventions and had not been revised since a specific date. When asked if they would expect that the care plan was updated to reflect the resident's care needs, the PCP stated yes.

In an interview with an Associate Director of Care (ADOC) on a specific date, the ADOC stated that the resident required transfer assistance and a specific mobility and transfer

devices after their fall. The ADOC identified the resident's current mobility and transfer needs. The ADOC reviewed the care plan related to mobility and transfer status for the resident and stated that the care plan was not up to date. When asked if they would expect that interventions related to the resident's current transfer and mobility status be included in their written plan of care, the ADOC stated yes.

The licensee has failed to ensure that the written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident related to mobility and transfer status. [s. 6. (1) (c)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home on a specific date, related to an allegation of staff to resident abuse, whereby the Registered Practical Nurse (RPN) restricted a resident's mobility and left them sitting in their room without a call bell for over two hours.

In an interview on a specific date, the identified resident stated they were unable to recall if management had followed up with them on the investigation into their allegations of abuse against staff.

Review of the resident's electronic progress notes and home's investigative notes noted no documentation related to the monitoring of effects of the abuse on the resident after the incident.

Review of St. Joseph's Health Care policy Abuse and Neglect of Residents: Zero Tolerance, review date November 8, 2016, noted the following: "During the course of the investigation, leaders must: Fully investigate and document all known details of the reported incident. Clinical staff responsible for the care of the resident harmed by the alleged, suspected or witnessed abuse of neglect should: Provide interventions for the resident who has been or allegedly abused or neglected and their roommates where appropriate. Document and communicate that status of the resident's health condition, further assessments arranged, and health investigation findings to the Coordinator/Director of Mount Hope."

In an interview on a specific date, an Associate Director of Care stated they had spoken to the resident regarding their allegations of abuse on a specific date, and then followed up with the resident after the investigation into the allegations of abuse was completed. The ADOC stated they had not documented any of the conversations they had with the resident. The ADOC confirmed that they should have documented their discussions with the resident as part of their investigation into the allegations of abuse. The ADOC stated that they had checked in with the resident after the abuse to see how they were doing, but that they had not documented this. The ADOC stated there should have been documentation by the registered staff of monitoring the effects of the abuse on the resident in the resident's progress notes.

In an interview on a specific date, the Executive Director stated that the interview and follow up with the resident should have been documented and there should have been follow up on the status of the resident after the abuse and this should have been documented.

The licensee had failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of resident was complied with. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home had received training related to the following:
- The Residents' Bill of Rights;
- The home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty to make mandatory reports under section 24;
- The whistle-blowing protections afforded under section 26.

In an interview on a specific date, a housekeeper stated they were a contracted employee and had not received training related to abuse and neglect specific to Mount Hope's policies on abuse.

The Long Term-Care Homes Act 2007, defines staff as "persons who work at the home pursuant to a contract or agreement with the licensee."

In an interview on a specific date, an Environmental Services Manager (ESM) stated that housekeeping staff were contracted through a company. The ESM reviewed training on abuse and neglect for 2017 and stated the only training that the housekeeping staff had received was face to face training on sexual abuse in August 2017.

In an interview on a specific date, the Executive Director (ED) stated that the housekeeping staff should have received training on abuse and neglect through Learning Edge, which was the home's electronic training system. The ED confirmed that the housekeeping staff did not receive training on the above areas related to abuse and neglect. [s. 76. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

In an interview on a specific date, the Executive Director (ED) stated that the home had completed an annual evaluation of the home's abuse policy.

On a specific date, the ED confirmed with an inspector that they could not locate documentation related to a formal annual review to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. [s. 99. (b)]

Issued on this 26th day of November, 2018

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

Original report signed by the inspector.