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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2019_508137_0003	008096-18, 009229-18, 016177-18, 025911-18, 026472-18, 027553-18, 028526-18, 029746-18, 030474-18, 031202-18, 033224-18, 033423-18	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

MARIAN MACDONALD (137), AMBERLY KERR (435), DONNA TIERNEY (569), HELENE DESABRAIS (615)

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 16-18 and 21-24, 2019

During the course of the inspection, the inspector(s) spoke with the Executive Director, Interim Director of Care, Associate Directors of Care, Administrative Assistant, Physician, Occupational Therapy Assistant, Registered Staff, Personal Care Providers (PCP), family members and residents.

Inspectors also observed provision of care, staff and resident interactions, availability of fall prevention devices, reviewed residents' clinical records, internal investigative notes, staff education records, police record checks for identified staff members, home's correspondence with residents and/or Powers of Attorney (POA) and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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	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 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 there was a written plan of care for each resident that sets out the planned care for the resident.

A Critical Incident System (CIS) report C596-000119-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to an incident where an identified resident sustained an injury while being transported. The resident's assistive device was not equipped with attachments to ensure safe transport and to mitigate injury. The resident required an external medical assessment.

As a result of the incident, the long term actions, to ensure safe transport and to mitigate injury, were determined to be that the resident's assistive device be equipped with the required attachments, at all times during transport.

Identified staff members said the use of the attachments was to be documented on the plan of care, kardex and tasks, as well as signage in the resident's room indicating that the attachments were to be used for transport.
A record review of the identified resident's care plan, kardex and tasks showed that there was no documented evidence that specified the resident's assistive device was to be equipped with the required attachments when transporting the resident. An Associate Director of Care (ADOC) acknowledged that those care requirements were not documented in the plan of care for the identified resident and expected them to be documented.

Observations of the resident's room showed that there was no signage that directed staff to apply the required attachments to the resident's assistive device during transport.

The licensee has failed to ensure that there was a written plan of care that set out the planned care for the identified resident, specifically related to ensuring that the assistive device was to be equipped with the required attachments, when transporting the resident. [s. 6. (1) (a)] (569)

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: 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 there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that it was complied with. 2007, c. 8, s. 20 (1).

A Critical Incident System (CIS) report C596-000095-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an alleged incident of emotional abuse by staff to an identified resident.

The Ontario Regulation 79/10 defines “emotional abuse” as 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 review of the CIS report outlined an incident in which an identified resident reported to a health professional that they were administered a medication in an inappropriate manner and against their wish. The report stated that the resident did not have an order for the medication and the resident was cognitively able to make their own decisions.

A review of the Patient Safety Reporting System showed the incident was not reported to the MOHLTC until three days after it occurred.

A review of the Home's policy "Abuse and Neglect of Residents: Zero Tolerance" last reviewed November 8, 2016, stated in part "Overview of Investigation and Reporting of Abuse and Neglect: Investigation and Reporting: Staff/affiliates must immediately report to the Ministry of Health and Long Term Care (MOHLTC) every alleged, suspected or witnessed incidents of: Abuse of a resident by anyone".

During an interview, the Executive Director stated that the home’s expectation that any allegation of abuse be reported immediately to the Director.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c. 8, s. 20 (1). [s. 20. (1)] (435)

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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report #C596-000098- 18 was submitted to the Ministry of Health and Long Term Care (MOHLTC), related to an alleged incident of emotional abuse by staff to an identified resident.

The Ontario Regulation 79/10 defines "emotional abuse" as 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 review of the Home's policy "abuse and Neglect of Residents: Zero Tolerance" last reviewed November 8, 2016, stated in part "Overview of Investigation and Reporting of Abuse and Neglect: Investigation and Reporting: Staff/affiliates must immediately report to the Ministry of Health and Long Term Care (MOHLTC) every alleged, suspected or witnessed incidents of: Abuse of a resident by anyone".

A review of the home's investigation documents included meeting notes that said the identified staff member's tone was condescending when they spoke to the resident, which caused emotional distress to the resident.

During three staff interviews, all stated that they would report suspected abuse of a resident immediately to the MOHLTC.

During interviews, the ED and a Registered Nurse (RN) said that the incident was emotional abuse and the home's expectation was that it should have been reported immediately to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of an identified 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)] (615)

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 a person who has reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report C596-000065-18 was submitted to the MOHLTC,

related to an incident of alleged staff to resident physical abuse, resulting in impaired skin integrity to an identified resident.

A review of the home's policy titled "Skin Care and Assessment, and Wound Management" last revised August 2017, stated in part "Assessment of all residents: All permanent Mount Hope residents and respite residents will receive a head-to-toe skin assessment performed by the Registered Nurse (RN) or Registered Practical Nurse (RPN): any time there is a significant change in health or skin integrity status. The head-to-toe assessment is documented in the electronic documentation system, using the "Head-to-Toe Skin Assessment tool" or "Wound/Skin Assessment".

A clinical record for the identified resident showed that there was no documented evidence in Point Click Care (PCC) that a Head-to-Toe or Skin and Wound Assessment was completed.
During interviews, registered staff said that a Skin and Wound assessment should be completed when a new area of impaired skin integrity was noted for a resident. Both registered staff members reviewed the resident's clinical record and said that there were no skin assessments completed for the resident and should have been completed to be able to develop treatment and interventions.

During an interview, the ED stated that the home's expectation was that when a new area of impaired skin integrity was noted for a resident, a skin and wound assessment should be completed.

The licensee has failed to ensure that the identified resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, related to the resident's new area of impaired skin integrity.
[s. 50. (2) (b) (i)] (615)

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident System (CIS) report #C596-000098-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC), related to an alleged incident of emotional abuse by staff to an identified resident.

The Ontario Regulation 79/10 defines “emotional abuse” as 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 review of the Home's policy "Abuse and Neglect of Residents: Zero Tolerance" last reviewed November 8, 2016, stated in part "Overview of Investigation and Reporting of Abuse and Neglect: Investigation and Reporting: Mount Hope will notify the resident's SDM (if any) and any other person the resident specifies: immediately upon Mount Hope becoming aware of an alleged, suspected or witnessed incidents of: Abuse of a resident by anyone".

A review of the home's investigation documents included meeting notes that said the identified staff member’s tone was condescending when they spoke to the resident, which caused emotional distress to the resident but it did not include that the identified resident’s Substitute Decision Maker (SDM) was notified of the incident. The CIS indicated that the SDM was not immediately notified of the incident.

During interviews, the ED and RN said that the incident was emotional abuse and the home's expectation was that it should have been reported to the SDM immediately.

The licensee has failed to ensure that the resident’s SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (a)] (615)

2. The licensee has failed to ensure that the resident and the resident’s substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

A CIS report C596-000095-18 was submitted to the MOHLTC related to an alleged incident of emotional abuse by staff to an identified resident.

A review of the CIS report outlined an incident in which an identified resident reported to

a health professional that they were administered a medication in an inappropriate manner and against their wish. The report stated that the resident did not have an order for the medication and the resident was cognitively able to make their own decisions.

A review of the Patient Safety Reporting System showed the incident was not reported to the MOHLTC until three days after it occurred.

During interviews, identified staff stated that the resident was cognitively able to direct their own care.

A review of the home's investigation notes, progress notes found on Point Click Care (PCC) and assessments found on PCC showed there was no documented evidence that the home followed up with the resident immediately after the completion of the investigation.

During an interview, the Executive Director (ED) said that the home's expectation would be that any follow up completed with the resident or their substitute decision maker would be documented in the home's investigation notes folder or in the resident's progress notes found on PCC. The ED could not confirm if the resident was followed up with as there was no documented evidence to indicate that the follow up occurred.

The licensee has failed to ensure that the resident was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.
[s. 97. (2)] (435)

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.