Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 7, 2020	2020_648741_0006	001635-20, 003133-20, 004168-20, 004364-20, 005043-20, 006903-20, 008945-20, 009836-20, 012211-20, 012511-20	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

AYESHA SARATHY (741), KRISTEN MURRAY (731)

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): June 10 and 26, 2020 on-site and June 11-25, 29 and 30, 2020 off-site

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

CIS #C596-00005-20 related to falls prevention and management
CIS #C596-00010-20 related to resident to resident abuse
CIS #C596-00012-20 related to falls prevention and management
CIS #C596-00014-20 related to resident to resident abuse
CIS #C596-00015-20 related to falls prevention and management
CIS #C596-00021-20 related to missing controlled substance
CIS #C596-00024-20 related to resident to resident abuse
CIS #C596-00026-20 related to falls prevention and management
CIS #C596-00034-20 related to falls prevention and management
CIS #C596-00037-20 related to missing controlled substance

During the course of the inspection, the inspector(s) spoke with One to one Health Care Workers (HCWs), Personal Support Workers (PSWs), Primary Care Providers (PCPs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Associate Directors of Care (ADOCs), the Director of Care (DOC), the Executive Director (ED) and residents.

The Inspector also observed residents and storage of controlled substances in medication rooms, and reviewed relevant policies and procedures, Patient Safety Reporting System (PSRS) incident reports and clinical records for identified residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **1 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. 20. Policy to promote zero tolerance

Findings/Faits saillants :

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

On an identified date, the Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS), related to an altercation between two residents, that resulted in injury to one of the residents. The CIS stated that both residents were walking down different hallways and met on the corner, where one resident reacted by pushing the other resident, who fell and landed on the floor.

Progress notes related to the incident were reviewed on Point Click Care (PCC) and indicated that the resident who was pushed and fell to the floor was assessed at the time of the incident and did not have any visible injuries. A progress note was documented by a Registered Practical Nurse (RPN) the next day, and stated that while staff provided care to the resident, a new injury was found on their body.

The home's "Prevention of Abuse and Neglect of a Resident" policy, last revised on April 7, 2020, was reviewed, and stated that the procedure for team members who witness or have knowledge of an incident that constitutes resident abuse is to immediately inform the Executive Director, designate and/or Charge Nurse. The Charge Nurse is responsible to contact the Executive Director or designate and complete the documentation for the MOLTC.

During an interview with an Associate Director of Care (ADOC), they said that the injury found on the resident's body was reported to a Registered Nurse (RN), but the RN did not immediately notify a manager. The ADOC said that the home's expectation is for RNs to notify a manager when they become aware of an incident of abuse and the manager would provide direction on reporting.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when the RN did not immediately notify management of the injury sustained by the identified resident as a result of physical abuse by another resident. [s. 20.]

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 in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

Issued on this 8th day of July, 2020

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

Original report signed by the inspector.