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_0007	009242-20, 010731-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint 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 complaints were inspected as a part of this inspection:

IL-77815-LO related to falls prevention, oral care and personal hygiene and grooming
IL-78582-LO related to skin and wound care, oral care and plan of care

Inspector #731 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Associate Directors of Care (ADOCs), the Director of Care (DOC), the Executive Director (ED), complainants and residents.

The Inspector also observed residents 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
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MOLTC) received a complaint through the Infoline, related to concerns with an identified resident's plan of care for falls prevention not being followed. The complainant said they were made aware that the resident had a fall in their room on a particular date and that their plan of care was not followed at the time of the fall.

The identified resident's clinical record was reviewed in Point Click Care (PCC). A Registered Nurse (RN) completed the documentation for the review and assessment of the fall and described the circumstances around the un-witnessed fall. It was documented that the resident had a fall in their room when they self-transferred from their chair to their bed. It was also documented that the call bell was tied to the bed rail and out of the resident's reach at the time of the fall.

The resident's most recent Falls Risk Assessment was reviewed and indicated that the resident was at high risk for falls and had a history of falls.

The resident's Care Plan was also reviewed on PCC and indicated that an intervention was put in place related to their risk of falls which directed staff to ensure that the call bell was always within the resident's reach.

During an interview with an RN, they said that the resident was having a meal in their room and had gotten up to go to the washroom and then to bed without assistance. They said that the resident told them that they called out for assistance. The RN said that the

call bell should have been within the resident's reach when they were in their room.

An Associate Director of Care (ADOC) was interviewed about the incident and they said that the resident's call bell was not within their reach when they were in their room and it should have been.

The licensee failed to ensure that the identified resident's call bell was placed within their reach as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A. The Ministry of Long-Term Care (MOLTC) received a complaint through the Infoline from a complainant with concerns related to the management and treatment of a pressure wound that an identified resident developed in the home.

The resident's clinical record was reviewed in Point Click Care (PCC) in relation to the management of the wound. The quarterly Braden Scale for Predicting Pressure Ulcer Risk was completed for the resident and indicated that the resident was at moderate risk for developing pressure ulcers, related to slightly limited sensory perception, occasionally moist skin, chairfast activity level, very limited mobility, probably inadequate nutrition and a problem with friction and shear which required frequent positioning with maximum assistance.

The resident's Care Plan and Kardex were reviewed and indicated that staff were required to turn and reposition the resident every two hours while in bed or up in their chair to promote skin integrity.

Documentation by staff for turning and repositioning the resident was reviewed on Point of Care (POC), and indicated that "Turning and Repositioning" was not included as a task for staff to document on; therefore, there was no evidence that the resident had been turned and repositioned by staff every two hours when in bed or in their chair.

During separate interviews with two Personal Support Workers (PSWs), they said that an intervention used by staff to promote the integrity of residents' skin was to reposition residents who require repositioning every two hours. They said that if a resident required turning and repositioning every two hours, it would come up on POC as a task and they would need to click off on it once every shift.

An Associate Director of Care (ADOC) said in an interview that “Turning and Repositioning” was documented in the resident’s Kardex but not found in the tasks for staff to document on. They said that on orientation, registered staff are trained on how to cue a task list when adapting residents’ care plans. They said that the registered staff member who updated the resident’s care plan with the intervention did not add it to the task list for documentation and should have.

B. An identified resident’s clinical record was reviewed as a part of an expanded sample size for this inspection.

The resident’s Quarterly Minimum Data Set (MDS) Assessment was reviewed and indicated that the resident required turning and repositioning as a part of their skin treatments.

The resident’s Care Plan and Kardex indicated that the resident was at risk for impaired skin integrity and had interventions under Bed Mobility and Acute/Chronic pain to turn and reposition every two hours and as needed.

The resident’s task list was reviewed on POC and there was no evidence indicating that “Turning and Repositioning” was included on the list for staff to document on.

In an interview with an ADOC, they reviewed the POC tasks for the resident and said that “Turning and Repositioning” was not included in their task list and should have been.

C. An identified resident’s clinical record was reviewed as a part of an expanded sample size for this inspection.

The resident’s Quarterly MDS Assessment was reviewed and indicated that the resident required turning and repositioning as a part of their skin treatments.

A review of resident’s Care Plan and Kardex indicated that the resident was at low risk for impaired skin integrity and required turning and repositioning every two hours and as needed for Bed Mobility.

The resident’s task list was reviewed on POC and there was no evidence indicating that “Turning and Repositioning” was included on the list for staff to document on.

In an interview with an ADOC, they reviewed the POC tasks for the resident and said that "Turning and Repositioning" was not included in their task list and should have been.

The licensee failed to ensure that the provision of care set out in three identified resident's plans of care for turning and repositioning was documented. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; and the final resolution, if any.

The Ministry of Long-Term Care (MOLTC) received a complaint through the Infoline from a complainant with concerns related to skin and wound care and oral care of an identified resident as well as concerns that the Power of Attorney (POA) had not been provided with the opportunity to participate in decisions involving the resident's care. The complainant stated that they lodged a written complaint with the home on a particular date, and that the home sent the complainant an initial response three days later, followed by another response 12 days later that addressed the complainant's concerns.

The home's documentation for the complaint related to the identified resident was reviewed, and the following documents were provided to the Inspector:

1) An email sent by a former Director of Care (DOC) to Centralized Intake, Assessment and Triage Team (CIATT), forwarding the complaint and the home's response to the complainant's concerns;
2) The home's letter of response to the complainant that addressed the concerns; and
3) A second letter sent by the complainant to the home months later, stating that upon receiving the home's response letter, they were still unsatisfied.

The home's Complaint policy titled "Complaints: Management of Resident, Family or Other Complaints", last revised in August 2019, was reviewed. The procedure for dealing with written complaints stated, in part, that the leader of designate would:

- Conduct and document an internal investigation using the "Mount Hope Centre for Long-Term Care Complaints Form" and ensure the documentation included the nature of the written complaint, the date the complaint was received, the type of action taken to resolve complaint, including date of action, timeframes for actions, and any follow-up action required, final resolutions, every date on which any response was provided to the complainant and description of response, and any response made by the complainant.
- File all written complaint investigations in the Complaints hard copy file
- Log written complaint and actions in the on-line Complaints file.

During an interview with an Associate Director of Care (ADOC), they stated that the process for dealing with complaints received was to follow the home's Complaint policy, send a response to the complainant informing them that the home is looking into the complaint, follow up with the complainant with the results of the investigation and determine if the complainant is satisfied, complete the "Mount Hope Centre for Long-Term Care Complaints Form" and keep the complaint file in the main office. They said that they were not able to find the complaint file for the identified resident and that it may

have been lost due to changes in management.

During another interview with the Executive Director (ED), they stated that the home did not have any other documentation related to the complaint other than what was provided to the Inspector.

The licensee failed to ensure that a documented record of the complaint related to the identified resident was kept in the home that included the nature of the written complaint, the date the complaint was received and the final resolution. [s. 101. (2)]

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.