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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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130, avenue Dufferin 4ème étage
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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
Jun 8, 2021	2021_886630_0021	006776-21	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

AMIE GIBBS-WARD (630)

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): May 31, June 1 and 2, 2021.

The following Complaint intakes were completed within this inspection:
Log # 006776-21 related to posting of the Ministry of Long-Term care Action Line, Infection Prevention and Control (IPAC) practices and residents' rights.

Inspector Loma Puckerin (#705241) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), an Associate Director of Care (ADOC), a Registered Nurses (RN), a Registered Practical Nurse (RPN), a Public Health Nurse/Investigator and residents.

The inspectors also observed resident rooms and common areas, observed the resident smoking area, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 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 three residents during a suspected COVID-19 outbreak, that set out the planned care for the resident, the goals the care was intended to achieve and provided clear directions to staff.

During a suspected COVID-19 outbreak in the home there were specific interventions implemented for the residents with the intention to promote the residents' compliance with the Droplet and Contact precaution isolation requirements. The interventions that were in place were upsetting to two of the three residents and all three residents were non-compliant with the interventions. During a previous outbreak there was a supervised smoking schedule put in place for the residents, but this had not been implemented at the start of this outbreak and this caused confusion for staff and residents. The residents' written plans of care during the suspected outbreak did not include goals adjusted to their care needs and did not provide clear directions to staff in order to effectively address these care concerns, which placed them at risk of harm related to Infection Prevention and Control (IPAC), mobility and smoking safety.

Sources: Interview with a resident; interview with a family member; written letters to residents from the management in the home; the residents' plans of care and other clinical records; interview with a Public Health Nurse/Investigator; and interviews with staff. [s. 6. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Ministry of Long-Term Care (MLTC)'s toll-free telephone number for making complaints about homes and its hours of service, was posted in the home in a conspicuous and easily accessible location in a manner that complied with the requirements established by the regulations.

LTCHA s.79 (1) and (3) (q) requires information to be posted in the home in accordance with the regulations.

O. Reg. 79/10, s 225 (1) 4. requires the home post and communicate to residents under section 79 of the Act the Ministry's toll-free telephone number for making complaints about homes and its hours of service.

During the inspection a resident and their family identified that they had requested the MLTC's complaint phone number and staff did not provide it as they did not know the number. They also reported that they did not think it was posted in a place where residents could see it in the home.

During observations of common resident areas through out the home there were no visible postings of the MLTC's toll-free telephone number. Upon observation with one of the Assistant Directors of Care (ADOC) they acknowledged that the telephone number was not posted. The Administrator acknowledged that it was the expectation that the MLTC toll-free telephone number would be posted in locations accessible to residents. Residents not having access to this information placed them at risk for not being able to independently report their care concerns to the MLTC.

Sources: Observations of resident common areas of the home; interview with a resident; and interviews with an ADOC and other staff. [s. 79. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's hand hygiene (HH) program was implemented in accordance with the Ontario evidence-based HH program, "Just Clean Your Hands" (JCYH) to support resident HH when entering and leaving a common gathering area of the home.

During interviews with residents and staff it was reported that the centre courtyard of the home had been designated as a temporary smoking area for residents during the COVID-19 pandemic. Based on observations during the inspection there were multiple residents and staff entering and exiting this courtyard through a door in between the hallway coming from Marian Villa and the main lobby of St Mary's. During these observations it was identified that there was no alcohol based hand sanitizer (ABHS) accessible to residents or staff at the door or in the vicinity of this area. Based on interviews with a Public Health Nurse, a registered nursing staff member and the Director of Care (DOC) they said they would expect there to be ABHS available to residents and staff in this area as part of the home's Infection Prevention and Control Program to promote resident HH. The DOC said there were to be individual ABHS bottles in that area as there were no wall mounted dispensing stations at that door.

Sources: Observations courtyard on the main floor; interviews with a Public Health Nurse/Investigator and other staff of the home; interview with a resident; the home's policy Additional Precautions policy last revised January 2020 and "Just Clean Your Hands" program resources. [s. 229. (9)]

Issued on this 15th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2021_886630_0021
Log No. / No de registre :	006776-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 8, 2021
Licensee / Titulaire de permis :	St. Joseph's Health Care, London 268 Grosvenor Street, P.O. Box 5777, London, ON, N6A-4V2
LTC Home / Foyer de SLD :	Mount Hope Centre for Long Term Care 21 Grosvenor Street, P.O. Box 5777, London, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrew Adamyk

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To St. Joseph's Health Care, London, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA.

Specifically, the licensee must:

Ensure the plan of care for a resident provides clear direction for staff related to mobility, smoking safety and Infection Prevention and Control (IPAC) care, including at any time when the resident is in isolation for the purpose of IPAC.

Ensure the plan of care for another resident provides clear direction for staff related to smoking safety and IPAC care, including at any time when the resident is in isolation for the purpose of IPAC.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for three residents during a suspected COVID-19 outbreak, that set out the planned care for the resident, the goals the care was intended to achieve and provided clear directions to staff.

During a suspected COVID-19 outbreak in the home there were specific interventions implemented for the residents with the intention to promote the residents' compliance with the Droplet and Contact precaution isolation requirements. The interventions that were in place were upsetting to two of the three residents and all three residents were non-compliant with the interventions. During a previous outbreak there was a supervised smoking schedule put in place for the residents, but this had not been implemented at the start of this outbreak and this caused confusion for staff and residents. The residents' written plans of care during the suspected outbreak did not include goals adjusted to their care needs and did not provide clear directions to staff in order to effectively address these care concerns, which placed them at risk of harm related to Infection Prevention and Control (IPAC), mobility and smoking safety.

Sources: Interview with a resident; interview with a family member; written letters to residents from the management in the home; the residents' plans of care and other clinical records; interview with a Public Health Nurse/Investigator; and interviews with staff. [s. 6. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to three residents in relation to unsafe smoking practices and non-compliance with IPAC safety requirements.

Scope:This non-compliance was widespread as three out of three residents inspected did not have clear direction in their written plan of care.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (1) and one Voluntary Plan of Correction (VPC) and one Written Notifications (WNs) were issued to the home. (630)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

Service Area Office /
Bureau régional de services : London Service Area Office