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

London Service Area Office
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Original Public Report

Report Issue Date July 4, 2022
Inspection Number 2022_1520_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's Health Care, London

Long-Term Care Home and City
Mount Hope Centre for Long Term Care, London

Lead Inspector
Stephanie Morrison (721442)

Inspector Digital Signature
Peter Benjamin Hannaberg
Digitally signed by Peter Benjamin Hannaberg
Date: 2022.07.04 13:46:14 -04'00'

Additional Inspector(s)
Tatiana Pyper (733564)
Inspector #740899 (Karen Honey) was also present during this inspection.
Inspector #721821 (Peter Hannaberg) served this inspection report on behalf of Inspector #721442.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 24, 25, 26, 27, 30, and 31, and June 1, and 2, 2022.

The following intake(s) were inspected:

- Intake: 006111-22 Critical Incident System (CIS) # C596-000015-22 related to falls prevention and management
- Intake: 008547-22 CIS #C596-000024-22 related to falls prevention and management
- Intake: 009007-22 CIS #C596-000026-22 related to falls prevention and management
- Intake: 009312-22 CIS #C596-000030-22 related to falls prevention and management
- Intake: 007829-22 CIS #C596-000023-22 related to an allegation of physical abuse
- Intake: 003039-22 Follow up to Compliance Order (CO) #001 issued on March 2, 2022, under Inspection Report #2022_988522_0001 related to the Long-Term Care Homes Act (LTCHA), 2007, s. 5 (Safe and Secure Home) with a compliance due date of March 16, 2022
- Intake: 003040-22 Follow up to CO #002 issued on March 2, 2022, under Inspection Report #2022_988522_0001 related to the LTCHA, 2007, s. 76 (4) (Training) with a compliance due date of March 16, 2022

- Intake: 003038-22 Follow up to CO #003 issued on March 2, 2022, under Inspection Report #2022_988522_0001 related to the Ontario Regulation 79/10, s. 229 (4) (Infection Prevention and Control Program) with a compliance due date of March 16, 2022
- Intake: 003033-22 Follow up to CO #001 issued on February 16, 2022, under Inspection Report #2022_988522_0002 related to the O. Reg. 79/10, s. 33 (1) (Bathing) with a compliance due date of May 13, 2022
- Intake: 003034-22 Follow up to CO #002 issued on February 16, 2022, Inspection Report # 2022_988522_0002 related to the O. Reg. 79/10, s. 8 (1) (Policies) with a compliance due date of May 13, 2022

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 5	2022_988522_0001	001	Stephanie Morrison (721442)
LTCHA, 2007	s. 76 (4)	2022_988522_0001	002	Stephanie Morrison (721442)
O. Reg. 79/10	s. 33 (1)	2022_988522_0002	001	Tatiana Pyper (733564)
O. Reg. 79/10	s. 8 (1)	2022_988522_0002	002	Tatiana Pyper (733564)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 229 (4)	2022_988522_0001	003	Stephanie Morrison (721442)

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure the COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, effective May 3, 2022, was carried out in the home by not actively screening all persons for symptoms of COVID-19 before allowing entry to the home.

Rationale and Summary
Inspector #721442 was not actively screened upon entry to the home. The designated screener asked the inspector if they had any symptoms but did not list the symptoms. There was a list of COVID-19 symptoms posted at the screening desk, but the inspector was not prompted to read the symptoms. A visitor was observed to not be actively screened upon entry to the home. The visitor was asked if they had any symptoms, but the symptoms of COVID-19 were not listed to the visitor nor was the visitor prompted to read the posted symptoms.

The Interim Executive Director (ED) contacted the Vice President of communications and information was relayed to the screening coordinators to ensure active screening was completed. Inspector #721442 was actively screened for symptoms of COVID-19 for the subsequent several consecutive days of the inspection, and visitors were observed to be actively screened prior to entry to the home

Date Remedy Implemented: May 25, 2022 [712442]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL LEAD

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 23(4)

The licensee has failed to ensure the home had an infection prevention and control (IPAC) lead whose primary responsibility was the home's IPAC program.

Rationale and Summary
Section 102 (15) of the Ontario Regulation 246/22 specified a home, with a licensed bed capacity of 200 beds or more, was required to have a designated IPAC lead who worked regularly on site at the home for a minimum of 35 hours per week. The home had greater than 200 licenced bed capacity and therefore met the 35 hours per week requirement. The St. Joseph's IPAC Lead stated they work on site in the home one day per week. Interim Executive Director (ED) confirmed the home did not have an on site designated IPAC lead, and the home was actively recruiting to fill the position.

The home not having an on site designated IPAC Lead impacted the home's IPAC program, as evidenced by the three current outstanding IPAC-related compliance orders and other IPAC non-compliances observed in the home during the inspection.

Sources: Interviews with the St. Joseph's IPAC Lead, and Interim ED. [721442]

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WRITTEN NOTIFICATION DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 24(1)

The licensee has failed to ensure that a resident was protected from physical abuse by a security guard.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by anyone other than a resident that causes physical injury or pain”.

Rationale and Summary

A resident was exhibiting a responsive behaviour in a public area. According to the security guard’s statement in the security company’s internal incident report, the guard admitted they used “minimal amount of force and restrained” the resident by their arms and pushed the resident backwards to physically redirect, which caused the resident to fall. The resident sustained a bruise as a result of the incident. A Behaviour Support Ontario (BSO) staff member confirmed the written statement made by the security guard supported a finding of physical abuse of the resident.

The resident’s plan of care included interventions for responsive behaviours which did not include physical redirection. A BSO staff member stated the specific behaviour the resident was displaying in a public area had not created risk of injury to the resident or others, and physical redirection of the resident when they were exhibiting physical responsive behaviours was not an appropriate intervention.

A staff member who was on-duty at the time of the incident, stated they had not communicated the plan of care to the security guard involved prior to the incident of physical abuse, as they assumed the security guard had known the plan of care. Another staff member who was on-duty at the time of the incident, confirmed the resident’s plan of care had not been followed by the security guard. A BSO staff member explained there was a 1:1 binder accessible to the security guards which contained the resident’s plan of care with interventions for specific behaviours and a sheet for the security guards to sign-in and out. Review of the 1:1 binder showed the last recorded entry by a 1:1 staff was from prior to the incident, which, as per a BSO staff member, was prior to the switch of the 1:1 company to the current company. A BSO staff member stated the home’s frontline staff were expected to orientate new security guards to the binder and communicate interventions for the resident. There was no documented proof of such orientation. A full-time staff member stated they were not aware of the expectation to provide orientation to the security guards. Another full-time staff member stated they did not know what information was communicated to the security guards and did not know what the expectations were of the guards. During the inspection, a security guard, who was not involved in the incident, stated they did not know what the interventions were if the resident were to become physically aggressive as they had not received any direction from the home on what to do.

The home failed to protect the resident from physical abuse by not having communicated the plan of care for the resident's physical aggressive behaviours to the security guard who was caring for the resident.

Sources: Observations of resident-to-security guard interactions; Record review of Critical Incident System #C596-000023-22, resident health records, internal Incident Report from the security company, and the home's 1:1 binder; and Interviews with a security guard, a BSO staff member, and other staff. [721442]

WRITTEN NOTIFICATION BATHING

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 37(1)

The licensee has failed to ensure that a resident was bathed at a minimum, twice per week and more frequently as determined by the resident's requirements, unless contraindicated by a medical condition.

Rationale and Summary

During a review of a resident's bathing records, there was documentation indicating not-applicable (N/A). The resident was noted to have had an N/A bathing entry on a specific date. Review of the care plan indicated the resident was to be showered twice per week. During a review of the resident's bathing records, there was documentation indicating that the resident had not received their scheduled bathing for the week. A review of the resident's plan of care, it was noted that the resident had not received their scheduled shower as per their care plan.

During an interview with a staff member, it was indicated by them that the resident had not received a shower on the specific date, due to a shortage of staff. During an interview with another staff member, it was indicated by them that the resident had not received their shower on a specific date, and no attempts to provide a shower had been made during that week. During an interview with the Interim Executive Director (ED), it was indicated by them that the care plan for the resident had not been followed.

Not having completed the minimum of twice weekly showers posed a potential minimal impact to the resident's quality of life.

Sources: Review of CO #001 from inspection #2022_988522_0002, and resident clinical records; and Interviews with Interim ED, and other staff. [733564]

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WRITTEN NOTIFICATION SKIN AND WOUND

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55(2)(b)(iii)

The licensee has failed to ensure that two residents were assessed by a registered dietitian (RD) when the residents exhibited altered skin integrity.

Rationale and Summary

A resident sustained a fall, and a referral to the RD was made for a new wound related to trauma from the fall. A review of the resident's clinical records indicated that an assessment by the RD was not completed. During an interview with the Interim Executive Director (ED), it was indicated by them that the expectation of the home was that an assessment was to be made by the RD for a resident exhibiting altered skin integrity. [733564]

A second resident sustained an injury as a result of an incident. No assessment was completed by an RD for the impaired skin integrity to assess the resident's plan of care related to nutrition and hydration to promote wound healing. The RD stated the home does not always complete nutrition assessments for the type of trauma sustained by these residents, only if a referral was sent to prompt the assessment. [721442]

The RD not having assessed the plans of care for two residents to promote wound healing after the residents exhibited altered skin integrity created risk for potential delayed skin healing.

Sources: Review of resident health records; and Interviews with the RD, and Interim ED. [721442/733564]

WRITTEN NOTIFICATION HAZARDOUS SUBSTANCES

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 97

The licensee has failed to ensure all hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary

During the inspection, a bathing suite door was observed to be tied open with a plastic garbage bag on a specific unit. A cleaning product was hanging on the shower bar, accessible to residents. A staff member confirmed the bathing suite door should have been closed as it was a safety hazard.

The bathing suite door being tied open allowed residents access to a hazardous substance, which had the potential risk to cause harm to one or more residents.

Sources: Observations of a specific unit, and an interview with a staff member. [721442]

WRITTEN NOTIFICATION CONDITIONS OF LICENCE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 101(4)

Compliance Order (CO) #003 to O. Reg. 79/10, s. 229(4), related to all staff not participating in the implementation of the home's IPAC program, from Inspection #2022_988522_0001 was served to the licensee on March 2, 2022, with a compliance due date of March 16, 2022. CO #003 was found to be in noncompliance at the time of this inspection, as outlined below.

The licensee has failed to ensure that multiple staff on May 24, 25, 27, and 30, 2022, participated in the home's infection prevention and control (IPAC) program.

Rationale and Summary

On May 24, 2022, Personal Support Worker (PSW) #135 was observed to not be wearing eye protection while assisting a resident with their lunch. When asked why they were not wearing eye protection, PSW #135 stated they had forgotten. St. Joseph's IPAC Lead #113 stated any staff in a clinical area were to wear masks and eye protection. [721442]

On May 24, 27, and 30, 2022, various staff, including Hairstylist #111, were observed not wearing their PPE such as eye protection in clinical areas as per the home's IPAC program. Hairstylist #111 stated they had not received IPAC training. Review of email correspondence from Director Occupational Health and Safety and Infection Prevention Control for St. Joseph Hospital indicated staff were to wear eye protection and other PPE, while in clinical areas. In an interview, IPAC Lead #113 indicated all staff must wear eye protection along with their PPE, while in clinical areas. [733564]

On May 24, 2022, Screener #136 applied hand sanitizer overtop of their gloves while processing a rapid surveillance test. Screener #136 stated they applied the hand sanitizer to sanitize the gloves and make the gloves wet because their gloves were dry. St. Joseph's IPAC Lead #113 confirmed applying hand sanitizer on top of gloves was not an acceptable IPAC practice in the home. [721442]

On May 24, 2022, Personal Support Worker (PSW) #128 was observed taking a break in the open-concept nurse's station on Marian Villa fifth floor without a mask on. PSW #128 stated they often take breaks in the nurse's station. On May 27, 2022, Screener #134 was observed eating with their mask off in the surveillance testing area located in the home's front foyer. Screener #134 stated they sometimes take breaks in the surveillance testing area rather than

their designated break area. St. Joseph's IPAC Lead #113 stated staff are to keep their masks on at all times except in designated break areas, these designated break areas did not include the nurse's station or the surveillance testing area because both areas were accessible to residents. [721442]

On May 25, 2022, RPN #101 did not complete hand hygiene after they administered medications to a resident in Marian Villa first floor dining room, and they did not sanitize a resident-specific medication instrument after administration to the same resident. On May 27, 2022, RPN #103 did not complete hand hygiene after they administered medication to a resident in St. Mary's third floor dining room, and they did not sanitize a resident-specific medication instrument after administration to the same resident. On May 27, 2022, RPN #108 did not complete hand hygiene after they administered medication to a resident in St. Mary's fifth floor dining room, and they did not sanitize a resident-specific medication instrument after administration to the same resident. On May 30, 2022, RPN #109 did not complete hand hygiene after they administered medications to a resident in St. Mary's first floor dining room, and they did not sanitize a resident-specific medication instrument after administration to the same resident. RPNs #101, #103, #108, and #109 admitted they did not complete the required hand hygiene during the observed medication administrations. St. Joseph's IPAC Lead #113 confirmed the expectation was to complete hand hygiene after administering medication to each resident, sanitize resident-specific medication instruments after medication administration, and perform hand hygiene before preparing the next resident's medication. [733564]

On May 25, 2022, RPN #108 did not complete hand hygiene after they administered medications to three residents in the St. Mary's fifth floor dining room. RPN #108 admitted they did not complete the required hand hygiene during the observed medication administrations. St. Joseph's IPAC Lead #113 confirmed the expectation was to complete hand hygiene after administering medication to each resident and before preparing the next resident's medication. [721442]

On May 25, 2022, Food Services Worker (FSW) #131 was observed to be outside the home on their break with their mask pulled down under their chin. FSW #131 admitted they should have taken their mask off before their break but had forgotten to do so. St. Joseph's IPAC Lead #113 stated all staff were expected to doff their mask prior to their breaks, and FSW #131 having taken their break with their mask under their chin created risk of self-contamination. [721442]

On May 27, 2022, three staff members were observed entering the home not socially distanced the required six feet apart while not wearing masks. St. Joseph's IPAC Lead #113 confirmed the staff were expected to social distance six feet apart as much as possible and had put signage up as a reminder on the morning of May 27, 2022. [721442]

On May 27, 2022, resident #011 on St. Mary's second floor was on enhanced droplet/contact precautions. A small garbage can, without a lid, was observed to be inside a resident's room.

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On May 27, 2022, a second resident on St. Mary's second floor was on enhanced droplet/contact precautions. No garbage was observed to be inside or near the second resident's room. Neither resident had a garbage can with a lid for staff and visitors to doff their PPE into when leaving their rooms. Interim Executive Director (ED) #102 stated numerous garbage cans with lids had been purchased, but the staff were not reliably using them. [721442]

Multiple staff not having not participated in the home's IPAC program increased risk of spread of communicable diseases, including COVID-19.

Sources: Observations of the home's IPAC practices on May 24, 25, 27, and 30, 2022; Review of email correspondence from Director Occupational Health and Safety, and Infection Prevention and Control for St. Joseph's Health Care, Routine Practices Policy; and Interviews with Hairstylist #111, FSW #131, Screener #134, Screener #136, PSW #128, PSW #135, RPN # 101, RPN #103, RPN #108, RPN #109, St. Joseph's IPAC Lead #113, Staff Educator #138, and Interim ED #102. [721442/733564]