Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: March 9, 2023

Inspection Number: 2023-1520-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: St. Joseph's Health Care, London

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

Lead Inspector	**Inspector Digital Signature**
Tatiana Pyper (733564)	Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2023.03.09 15:20:09 -05'00'

Additional Inspector(s)
Christie Birch (740898)
Julie Lampman (522)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
-February 15, 16, 21, 22, and 24, 2023, on site.
-February 17 and 23, 2023, off site.

The following intake(s) were inspected:

- Intake #00001105, CI# C596-000042-22, and Intake #00019597, IL-09766-LO related to care and support services
- Intake #00014585, CI# 596-000072-22 related to maintenance services
- Intake #00015051, CI# 596-000073-22 related to safe and secure home
- Intake #00016316, CI# 596-000080-22 related to medication management

The following intake(s) were completed in this inspection:
Intake #00001110, CI# C596-000032-22, Intake #00002258, CI# C596-000043-22, Intake #00005618, CI# C596-000054-22, Intake #00007706, CI# C596-000056-22, Intake #00008692, CI # 596-000060-22, Intake #00011314, CI# 596-000062-22, Intake #00013905, CI# 596-000068-22, Intake #00014217, CI# 596-000069-22, Intake #00015253, CI# 596-000074-22, Intake #00015929, CI# 596-000078-22, Intake #00016277, CI# 596-000079-22, Intake #00017886, CI# 596-000003-23, and Intake #00018449, CI# 596-000006-23 related to fall prevention and management.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the COVID-19 Minister's Directive for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, effective April 27, 2022, was carried out in the home by not screening residents in the home at least once daily for symptoms of Covid-19, including temperature checks.

Rationale and Summary

1. On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s.184 (1) of the Fixing Long-Term Care Act, 2021. The Directive related to the safe operation of the LTCHs, specifically to reduce the risk of COVID-19.

COVID-19 guidance document for long-term care homes in Ontario updated December 23, 2022 states: "homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks."

A) Review of a resident's clinical records indicated that there was no temperature recorded for several days.

In an interview, Director of Care (DOC) and Infection Prevention and Control Lead (IPAC) stated that their expectation was that every resident was monitored daily for COVID-19 symptoms, including temperature check and their temperature readings recorded the in the electronical medical record Point

Click Care (PCC).

Sources: Review of resident's clinical records, interview with IPAC Lead and DOC.

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B) For a specific resident, no assessment of Covid-19 symptoms or temperatures were documented in Point Click Care (PCC) or paper documents on specific days.

In an interview with Director of Care (DOC), they confirmed that the expectation was that every resident was monitored daily with a temperature check and recorded in PCC. DOC confirmed they did not expect COVID-19 symptoms to be assessed and documented daily.

In an interview with Infection Prevention and Control (IPAC) Lead, they confirmed that every resident should have their temperatures taken daily and recorded in PCC.

In an interview with a Personal Support Worker (PSW), they confirmed that only temperatures were taken, residents were not asked about COVID-19 symptoms. The PSW also confirmed they were responsible to take the temperatures of every resident, every day in both buildings of the home. The PSW stated that on the days that they were not scheduled to work, someone else was assigned to check resident's temperatures. The PSW was able to confirm that the resident was often not in their room, so their temperature did not get taken.

Sources: Review of progress notes in PCC, COVID-19 screening documentation; review of vital signs records PCC; interviews with PSW, RPN and DOC.

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2. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A) Specifically, the licensee has failed to ensure that Routine Practices included hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 (b) that the licensee should ensure that Routine Practices and Additional Precautions included hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment

contact).

Review of the home's Infection Control, Hand Hygiene e-Learning noted that hand hygiene must be performed before putting on and after taking off personal protective equipment.

i) On specific dates, a Registered Practical Nurse (RPN) was observed donning a surgical mask without performing hand hygiene.
The RPN acknowledged they had not sanitized their hands while donning their mask and stated there was hand sanitizer around the corner that they would use.

ii) On a specific date, a Dietary Aide (DA) was observed donning a surgical mask in the dining room, without performing hand hygiene. The DA stated they washed their hands once they entered the kitchen. The DA gathered their belongings and went into kitchen and washed their hands.

iii) On a specific date, a PSW was observed donning a surgical mask without performing hand hygiene. Director of Care (DOC) stated staff should follow proper hand hygiene practices when they donned masks.

Staff not completing proper hand hygiene posed a risk of spreading healthcare associated infections.

Sources:
IPAC observations in the home, review of the home's "Hand Hygiene" policy #INF002 revised September 1, 2022, the home's Infection Control, Hand Hygiene e-Learning and interviews with RPN, DA and DOC.

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B) Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes dated August 30, 2022, states that licensees are required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario are carried out.

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, dated December 23, 2022, states the removal of masks for the purposes of eating should be restricted to areas designated by the home. Homes must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas. Masks must not be removed when staff are interacting with residents or in designated resident areas.

i) On a specific date, a Registered Practical Nurse (RPN) was observed seated without a mask at the end of the hallway of a home area. When the RPN saw Inspector #522 they put on their mask which had

been on a stack of books on the windowsill.

On a specific date, the RPN was again observed seated at the end of the hallway in a home area, eating without their mask.

The RPN stated they always took their break at the end of the hallway as they thought it was safer than the staff room.

ii) On a specific date, a Personal Support Worker (PSW) was observed seated at the end of the hallway in a home area. The PSW did not have a mask on and was drinking water. When the PSW saw Inspector #522 they put on their mask which had been on the windowsill.

The PSW acknowledged there were designated staff break rooms on the floor. The PSW stated they wanted to make a personal call and did not want to use the staff room, so they took their break at the end of the hallway.

Director of Care (DOC) stated there were designated break rooms for staff on each floor and staff were not to take breaks in resident areas or put their masks on the windowsill.

Staff removing their masks and taking breaks in a resident area increased the risk to residents, as residents may approach the staff member while they were unmasked.

Sources:
IPAC observations of the home and interviews with PSW, RPN and DOC.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program.

Rationale and Summary

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19. LTCHS were to practice the health and safety requirements contained in the directive which included personal protective equipment (PPE) requirements.

On a specific date, a staff member was observed entering the home area through the service elevators pushing a cart with garbage bags while wearing gloves. The staff member was observed entering the kitchen while wearing the gloves and pushing the cart with garbage bags. The staff member was observed loading the cart with additional garbage bags, then exiting the kitchen and entering a home area while wearing the same pair of gloves.

In an interview the Administrator stated that the staff member wearing gloves after handling garbage while pushing the cart with garbage does not meet the expectation of the home.

On a specific date, a Registered Practical Nurse (RPN) was observed taking gloves from the glove box dispenser in the hallway, putting the gloves in their pocket, performing hand hygiene and then entering a resident's room while donning the gloves from their pocket to assist in changing of a wound dressing.

On a specific date, a Personal Support Worker (PSW) was observed donning gloves, knocking on the doors of a resident's room, and then entering the room.

In an interview, Director of Care stated that the RPN and the PSW did not follow the Infection and Prevention Control practices as outlined in the Infection Prevention and Control Program.

Sources: Observations of IPAC practices in the home, interviews with PSW, RPN, DOC, and Administrator.

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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

FLTCA 2021, s. 28 (1) 1

The licensee failed to ensure that they immediately reported to the Director alleged improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm.

Rationale and Summary

Family member of a resident lodged a complaint with the Ministry of Long-Term Care, related to improper assessment of capacity to determine if the resident was capable to consent to transfer to hospital which could have impacted her treatment outcome.

Review of the home's Concerns and Complaints form noted that the family member of the resident believed the resident's capability was not accurately assessed by the staff and that they almost lost their life because of this oversight.

In an interview, the Assistant Director of Care (ADOC) confirmed that they were aware of the complaint from the family member of the resident that involved being unhappy with the way the resident's level of cognitive ability was assessed by staff at the time they were asked if they wanted to go to the hospital on a specific date. The ADOC also confirmed they were aware of the reporting requirements and that they had not reported this to the Ministry of Long-Term Care. The ADOC stated they felt the complaint was resolved.

In an interview, the Director of Care (DOC) confirmed they were aware of the reporting requirements, but they did not report because they felt at the time that the resident had received the care and treatment that they needed and therefore felt it was not reportable.

Sources: Review of clinical records in Point Click Care, Mount Hope Concerns and Complaints form and Interviews with ADOC and DOC.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care by the home. The CIS report indicated that a resident had been administered another resident's medications, which had not been prescribed to the resident.

A review of the resident's progress notes in Point Click Care (PCC) noted that the resident had been administered the medication in error on a specific date, the resident became ill. The resident was sent to the emergency department for further assessment and returned to the home later that evening.

A Registered Practical Nurse (RPN) stated they were distracted when they were administering the medication and accidentally administered the medication to another resident. The RPN stated as soon as the resident took the medication, they knew they had administered the medication to the wrong resident and took immediate action.

There was actual risk to the resident when they were administered the wrong medication and became ill.

Sources:
Review of CIS report #C596-000080-22, resident's clinical records, Patient Safety Reporting System event #166035 and interviews with resident, RPN and Director of Care.

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