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
Apr 29, 2021	2021_886630_0018	000149-21, 006174-21	Critical Incident System

Licensee/Titulaire de permis

peopleCare Communities Inc.
735 Bridge Street West Waterloo ON N2V 2H1

Long-Term Care Home/Foyer de soins de longue durée

peopleCare Tavistock
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): April 22, 23 and 26, 2021.

The following Critical Incident (CI) intakes were completed within this inspection:

Related to falls prevention and management:
Log #000149-21 / CI 2614-000001-21
Log #006174-21 / CI 2614-000002-21

An Infection Prevention and Control (IPAC) inspection was also completed within this inspection.

Inspector Catherine Ochnik was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC)/Infection Prevention and Control (IPAC) Program Lead, the Director of Resident Quality Outcomes/Falls Program Lead (DRQO), a Registered Practical Nurse (RPN), a Housekeeper, Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, 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 Critical Incident System (CIS) reports, reviewed the home's internal investigation reports, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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

- **1 WN(s)**
- **0 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was revised at any time when their care needs changed.

A resident had a change in their condition which resulted in changes to their care needs for transfers and mobility.

The plan of care had not been revised to reflect the resident's change in care needs. Staff said the resident was in the process of being reassessed by the multi-disciplinary team and that it could take up to another week for this to be completed and the plan of care updated. The Director of Care (DOC) said the resident's care needs had changed and acknowledged their plan of care did not reflect the resident's current needs. They said it was the expectation that these revisions would have been updated right away. The DOC said there had been no injuries or incident related to the plan of care not having been revised, however the lack of revision to the care plan placed resident at risk for falls.

Sources: a Critical Incident System (CIS) report; the resident's Kardex and other clinical records; interviews with a Personal Support Work (PSW) and other staff. [s. 6. (10) (b)]

Issued on this 3rd day of May, 2021

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

Original report signed by the inspector.