Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2018	2018_418615_0001	028551-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE WOMEN'S CHRISTIAN ASSOCIATION OF LONDON
2022 Kains Road LONDON ON N6A 0A8

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

McCORMICK HOME
2022 Kains Road LONDON ON N6K 0A8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

HELENE DESABRAIS (615), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 2, 3, 4 and 5, 2018.

The following inspections were conducted during the Resident Quality Inspection:

Critical Incident System (CIS) report #2965-000023-16/Log# 027136-16 related to prevention of falls;
Critical Incident System (CIS) report #2965-000012-17/Log# 024374-17 related to prevention of abuse and neglect;
Critical Incident System (CIS) report #2965-000011-17/Log# 018077-17 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Assistant Director of Resident Care (ADOC), the Manager of Life Enrichment, one Registered Practical Nurse-Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), 11 Registered Practical Nurses (RPNs), 12 Personal Support Workers (PSWs), the representatives for the Family Council and Residents' Council, three family members and over 20 residents.

During the course of the inspection, the inspector(s) also toured the resident home areas and common areas, medication rooms, observed resident care provision, resident/staff interaction, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **1 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	Legendé 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).

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 the plan of care that set out clear directions to staff and others who provided direct care to the resident.

The electronic health record for a resident was reviewed in Point Click Care (PCC) with the most recent Quarterly Minimum Data Set (MDS) Assessment. The assessment indicated that the resident was frequently incontinent and there had been no change from previous assessments. This resident also had falls documented in PCC..

The plan of care in PCC indicated specific interventions for the resident based upon their needs and to reduce fall risks.

During interviews, two PSWs and a RPN stated that the resident was a risk for falls and required specific interventions. They said that the interventions for residents should be indicated in the care plan, kardex and tasks in PCC for staff to follow.

During an interview, the DRC said that the expectation in the home was that specific interventions for residents should be indicated in the resident's plan of care, kardex and tasks in PCC. The DRC stated that the resident was a risk for falls and they found that most of this resident's falls occurred when the resident attempted to do the specific interventions on their own. The DRC said that the resident's needs were assessed and

the specific interventions in place to prevent falls. The DRC and the Inspector reviewed the resident's plan of care, kardex and tasks in PCC and found that the specific interventions were not identified anywhere to provide direction for PSWs.

The licensee has failed to ensure that the plan of care was setting out clear directions to staff and others who provide direct care to the resident related to specific interventions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On a specific date, a resident was observed using in a device.

The electronic health record for the resident was reviewed in PCC. The plan of care for the resident was reviewed and there was no indication that the resident was to be using the device. The plan also indicated that the resident required specific interventions. The "Resident Care Card" posted on the wall in the resident's room, indicated the use of different devices and specific interventions.

Tasks in Point of Care and the Kardex were also reviewed in PCC and there was no indication for the use of a other devices. A review of the physician's orders for the resident indicated the use of a PASD.

Progress notes documented by the Occupational Therapist, on a specific date, stated that the resident was assessed for the trial of a specific device and noted that the resident was observed using the device years prior. A further note documented by the Occupational Therapist stated that the purchase of the specific device would proceed after the trial.

Progress notes documented by the Physiotherapist, on a specific date, indicated the use of a the specific device with interventions with no indication of the use of the other different devices.

During staff interviews, a PSW and two RPNs, the PSW shared that the resident required a device for a specific intervention. The PSW and two RPNs could not recall when and how long the different device was used for the resident. The PSW stated that PSWs would follow the Resident Care Card posted on the wall in the resident's room for direction related to the interventions and the use of the devices. The plan of care in PCC

and the Resident Care Card in the resident's room were reviewed by two RPNs with the Inspector and the RPNs stated that the plan of care was not updated when the resident's needs changed and direction related to the use of the specific device was not included.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to the use of a device and interventions.

The severity of this non-compliance is potential for actual harm/risk and the scope is isolated. The home has a history of non-compliance related to this subsection of the legislation. A Voluntary Plan of Correction was issued in Critical Incident Inspection #2017_605523_0014 and in Resident Quality Inspection #2015_216144_0054. [s. 6. (10) (b)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident and, to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 9th day of January, 2018

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

Original report signed by the inspector.