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
Oct 12, 2021	2021_886630_0031	011050-21, 012466-21	Critical Incident System

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

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): October 1, 4, 5 and 6, 2021.

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

Related to falls prevention and management:
Log #011050-21 / CI 2965-000019-21

Related to the prevention of abuse and neglect:
Log #012466-21 / CI 2965-000023-21

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

Inspectors Loma Puckerin #705421 and Peter Hannaberg #721821 were also present for the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Infection Prevention and Control (IPAC) Program Lead/Assistant Director of Care (ADOC), the Clinical Registered Nurse (RN), the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) and Personal Support Worker (PSW), COVID-19 Screeners, a RPN, a Housekeeper, PSWs and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed IPAC practices within the home, observed residents and the care provided to them, reviewed CI reports, 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:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care that set out the planned care for a resident and provided clear directions to staff.

The resident's plan of care did not provide clear direction for staff regarding a specific area of their individual care needs. There was no direction for staff on the interventions they were to follow for the resident if they had a specific behaviour. The lack of clear direction in the resident's written plan of care placed them at risk for not receiving the care they required.

Sources: Observations; a Critical Incident System (CIS) report; the resident's plan of care and other clinical records; interviews with staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to them as specified in the plan on a specific date.

There was an incident that occurred with the resident which involved responsive behaviours. At the time of the incident, the resident's plan of care included specific interventions that were to be followed by staff. These interventions were not followed by the staff at the time.

Sources: A Critical Incident System (CIS) report; the resident's plan of care and other clinical records; the home's investigation documentation; interviews with staff. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and provides clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 12th day of October, 2021

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

Original report signed by the inspector.