Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 13, 2023	
Inspection Number: 2023-1448-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Women's Christian Association of London	
Long Term Care Home and City: McCormick Home, London	
Lead Inspector Meagan McGregor (721)	**Inspector Digital Signature** Meagan McGregor Digitally signed by Meagan McGregor Date: 2023.09.14 09:25:13 -04'00'
Additional Inspector(s) Rhonda Kukoly (213) Peter Hannaberg (721821)	

INSPECTION SUMMARY

The inspection occurred on-site on the following date(s): September 6-8, and 11-12, 2023.

The following intake was inspected:

- Intake: #00095685 - Proactive Compliance Inspection (PCI) 2023

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

Pain Management
Falls Prevention and Management

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. 6 (2)

The licensee has failed to ensure that care plans for three residents were based on the residents' assessed needs and preferences.

Rationale and Summary:
a) The plan of care for a resident had conflicting information related to their Activities of Daily Living (ADL's) and staff indicated that the resident required specific care related to their ADL's, which did not include all interventions listed in their plan of care.

The Resident Assessment Instrument (RAI) Coordinator said that staff updated part of the plan of care after a significant change, adding new interventions, but didn't review the entire care plan to remove things that were no longer applicable. The RAI Coordinator reviewed the plan of care with the Registered Practical Nurse on the unit and updated it to ensure it was fully based on the resident's needs.

b) The plan of care for a resident had conflicting and generic information related to their ADL's and staff indicated that the resident required specific care related to their ADL's, which did not include all interventions listed in their plan of care. The RAI Coordinator said that the care plan was not based on the resident's assessed needs, as it was the original care plan template, and immediately updated it to be specific to the resident's needs.

c) A resident said they were provided specific bathing care as per their preference. The plan of care for the resident indicated they were to be provided a different type of bathing care. Staff indicated that the

resident was always provided bathing care as per their preferred method and that the care plan was not accurate. The Assistant Director of Care said the care plan was not reflecting the resident's preferences and immediately updated the resident's care plan.

Sources: Health records for the residents, and resident and staff interviews. [213]

Date Remedy Implemented: September 12, 2023