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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2016	2016_303563_0027	022266-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PEOPLECARE OAKCROSSING LONDON
1242 Oakcrossing Road LONDON ON N6H 0G2

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

MELANIE NORTHEY (563), DONNA TIERNEY (569), NANCY JOHNSON (538), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 2 - 5, 8-12 and 16, 2016

The following intakes were completed within the RQI:
018882-15 - 2980-000025-15 Critical Incident related to misappropriation of residents money
023280-15 - IL-40242-LO Anonymous complaint related to sufficient staffing and

resident care
028758-15 - 2980-000039-15 Critical Incident related to alleged staff to resident abuse
032477-15 - 2980-000043-15 Critical Incident related to alleged staff to resident abuse
032553-15 - 2980-000041-15 Critical Incident related to falls
003701-16 - 2980-000003-16 Critical Incident related to family complaint of improper care
004355-16 - IL-43001-LO Anonymous complaint related to improper resident care
005413-16 - 2980-000049-15 Critical Incident related to falls
012749-16 - 2980-000015-16 Critical Incident related to alleged resident to resident abuse
015198-16 - 2980-000020-16 Critical Incident related to falls
015478-16 - 2980-000021-16 Critical Incident related to falls
015699-16 - 2980-000023-16 Critical Incident related to alleged staff to resident abuse
016888-16 - 2980-000028-16 Critical Incident related to falls
017167-16 - 2980-000024-16 Critical Incident related to falls
019268-16 - 2980-000029-16 Critical Incident related to falls
021441-16 - 2980-000030-16 Critical Incident related to falls

The following intakes were inspected at the same time as the RQI and can be found in a separate report(s):
008017-16 - IL-43635-LO Complaint related to use of side rails
008268-16 - IL-43697-LO Complaint related to improper resident care
008715-16 - IL-43554-LO Complaint related to multiple resident care concerns
009383-16 - IL-43860-LO Complaint related to improper resident care
013664-16 - IL-44406-LO Complaint related to multiple resident care concerns
020632-16 - IL-45592-LO Complaint related to behaviours and sufficient staffing

PLEASE NOTE: A Written Notification (WN) #1 and Voluntary Plan of Correction (VPC) under LTCHA, 2007, S.O 2007 c.8, s. 20 (1) identified in concurrent inspection #2016_303563_0028 / Log # 008268-16 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Executive Director of Care, two Assistant Directors of Resident Care, the Director of Food Services, one Pharmacist, the Supervisor of Environmental Services, the Director of Programs, Director of Resident Quality Outcomes, the

Registered Dietitian, the Office Manager, one Social Worker, the Nursing Staffing Manager, one Behvioural Supports Ontario Personal Support Worker, one Physiotherapy Assistant, one Dietary Aide, 23 Personal Support Workers, ten Registered Practical Nurses, three Registered Nurses, the Residents' Council President, six family members and 40 plus residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's "Abuse or Suspected Abuse/Neglect of a Resident" policy with reference number 005010.00, indicated that any employee upon becoming aware of potential or actual abuse would immediately safeguard the resident and notify the Charge Nurse.

A Personal Support Worker (PSW) stated that they would not report all forms of abuse to their supervisor, specifically verbal abuse. The PSW stated in a phone interview that they had not immediately reported a witnessed incident of abuse involving another PSW and a resident. The PSW had reported the incident several weeks later and acknowledged that they should have reported it immediately. The PSW stated in a phone interview that they had not reported alleged neglect of residents because they believed another staff member was going to take responsibility.

The Executive Director stated that it was the home's policy that any potential or actual abuse would be immediately reported and followed up with an investigation. [s. 20. (1)]

2. A former staff member shared that an incident occurred where a resident was not provided basic care. The complainant also shared that he/she witnessed a PSW staff member disconnect a device for this resident and that he/she did not report any of the witnessed or suspected neglect of this resident to the registered nursing staff or management.

The Executive Director of Resident Care (EDORC) shared that at no time did this former staff member report any form of neglect or abuse of any resident by anyone during the time of their employment. [s. 20. (1)]

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 written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review of the Minimum Data Set (MDS) admission assessment documented that the resident was incontinent.

The Assistant Director of Resident Care (ADORC) shared that a voiding diary was completed for three consecutive days from the day of admission for all residents regardless of their level of continence. Then when the voiding diary was completed in Point of Care (POC) by the PSWs for three days, the Registered Staff on the floor complete the Bladder and Bowel Continence Assessment - V4 in PointClickCare (PCC) using the information collected in POC.

The home’s "Continence and Bowel Management Program” policy with reference number 008010.00 stated, "Continence assessments are completed on admission to the Long Term Care (LTC) home as part of the 24 hour Care Plan.”

There was no documented evidence found of a Bladder and Bowel Continent Assessment completed for this resident since admission in PCC.

The ADORC agreed there was no continence assessments completed for this resident on admission that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. Record review of the Minimum Data Set (MDS) admission assessment documented that another resident was incontinent.

Both ADORCs agreed there was no Bladder and Bowel Continent Assessment completed for this resident on admission that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

As part of the home's infection prevention and control program, staff were required to follow their Contact Precautions policy.

Inspector #658 observed a contact precautions signage on the door of a resident's room that instructed staff to wear personal protective equipment (PPE). The PSW was not wearing the appropriate PPE when caring for the resident.

The PSW shared that they had come in for a shift to finish baths that were missed during the day shift. The PSW stated that they had not worn the appropriate PPE during the resident's bath and acknowledged that they were supposed to wear a gown since it was indicated on the signage.

A Registered Practical Nurse (RPN) explained that the resident had an infection and staff were required to wear the appropriate personal protective equipment during personal care.

The Assistant Director of Resident Care stated that all staff were required to follow the signage as posted for contact precautions. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A resident was observed seated at the dining table without the documented safety devices in place as per the task in Point of Care (POC).

Clinical record review of the progress note by an Occupational Therapist listed the use of several interventions to be put in place related to the safety of this resident.

Record review of the Personal Assistance Devices (PASD) policy with reference number 005520.00 states, "The Director of Nursing or designate will review quarterly by self or designate utilizing the Assessment in PCC."

A Personal Support Worker (PSW) shared that PSWs have not applied the safety device to the resident for several months. The PSW acknowledged that applying the safety device was listed as a task in POC. Interview with another PSW shared that they had never used the safety device for this resident. Both PSWs agreed that they had not informed the registered staff that the resident was no longer using the safety device at specific times.

The Assistant Director of Resident Care (ADORC) shared that they had completed the hard copy of the Personal Assistive Safety Device (PASD) assessment on from the information documented in the resident's electronic clinical record. The ADORC agreed that they had not observed the resident when completing the assessment. The ADOC shared that they were not aware that the staff have not been using the safety device for several months. The ADORC shared that they had not been informed that the safety device was no longer used for the resident.

The ADORC agreed that staff and others involved in the care of this resident did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the date and time of the incident.

Record review of the Critical Incident (CI) Report submitted to the Ministry of Health (MOH) stated the incident occurred on a date and time that differed from the date and time the incident actually occurred.

Record review of the home's investigation notes documented that the incident was reported by the resident to the Director of Resident Quality Outcome. The home's interview with the PSW suspected of abuse documented that the PSW was with the resident providing care at a specific time when the incident occurred.

The Executive Director of Resident Care (EDORC) shared that the wrong date and time was documented for the CI Report, that the same date the report was submitted to the MOH was recorded and not the actual date and time of the incident itself. The EDORC shared that the incident related to this resident occurred during morning care and not in the afternoon as documented in CI Report. [s. 104. (1) 1.]

2. The licensee has failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or were responding to the incident.

Record review of the Critical Incident (CI) Report related to staff to resident suspected abuse of a resident. The staff member suspected of verbal abuse towards the resident was not documented as part of the CI Report.

Record review of the home's investigation notes determined a Personal Support Worker (PSW) was interviewed as part of this investigation and a witness statement was written by the PSW. The CI Report did not document the PSW as a staff member who was present at the incident.

The EDORC shared that the name of the staff member accused of verbal abuse was not documented as part of the CI Report and the PSW who witnessed the abuse was also absent from the CI Report. [s. 104. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day following an injury to a resident for which the resident was taken to hospital resulting in a significant change in the resident's health condition.

Review of the Critical Incident (CI) Report submitted to the Ministry of Health stated that the CI was submitted over a month late. Review of the progress notes documented that the resident was transferred to hospital following a fall a month earlier than the CI submission date.

The RPN stated that they reported it to the Assistant Director of Resident Care (ADORC) immediately following a phone call from acute care indicating a significant injury.

The Assistant Director of Resident Care (ADORC) said that they were informed by the RPN and stated that in the absence of the Executive Director of Resident Care (EDORC) it was their responsibility to complete the Critical Incident Report for the Ministry of Health.

The EDORC shared that they were on vacation on the date of the incident and the CI was not submitted to the MOHLTC within one business day. [s. 107. (3) 4.]

Issued on this 8th day of September, 2016

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

Original report signed by the inspector.