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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 2020	2020_729615_0001	000402-20, 000404-20, 001279-20	Complaint

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 Oakcrossing London
1242 Oakcrossing Road LONDON ON N6H 0G2

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 16, 17, 21 and 23, 2020.

The following Complaints were inspected during this inspection:

Complaint #IL-73494-LO/Log #000402-19 related to medication, maintenance and personal support services;
Complaint #IL-73496-LO/Log #000404-20 related to medication, maintenance and personal support services;
Complaint #IL-73861-LO/Log #001279-20 related to care of a resident, plan of care and laundry.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (Acting DOC), two Assistants Director of Care (ADOCs), the Director of Accomodations, the Director of Programs (DP), one Registered Nurse (RN), one Registered Practical Nurse (RPN), one Cook, one Personal Support Worker-Behavioural Support Ontario (PSW-BSO), eight Personal Support Workers (PSWs) and residents.

During the course of this inspection the Inspector(s) observed the overall maintenance and cleanliness of the home and equipment, observed staff to resident interactions, observed the provision of care, observed medication administration, reviewed relevant internal documentation, reviewed relevant clinical, records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Medication
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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

4 WN(s)
4 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

On a specific date Complaint #IL-73861-LO/Log #001279-20 was submitted to the Ministry of Long Term Care related to care concerns of a resident.

During an interview with the complainant, they stated, in part, that Personal Support Workers when providing care to the resident, would throw the resident's clothes soiled with feces in the laundry for the complainant to wash. The complainant said that they approached staff and management many times in the home to complain about this and that it was never resolved.

Review of an internal email from Registered Nurse #105 to the Administrator previously sent, stated, in part, "Subject: [complainant] concern Laundry. Hi, [complainant] of the resident was concerned that staff are putting soiled laundry to resident's personal laundry bag without cleaning them. This has happened in the past and [complainant] brought forwards this to the management. [Complainant] usually do the laundry for resident but requested, if clothes are soiled with feces sent it to in house laundry or wash the area before putting it to the laundry bag. Discussed with the staff working this shift. Will have to follow up with rest of the staff working other shifts."

Review of the home's documentation titled "Wham Meeting" stated in part, "On June 21, 2019: Subject: Staff leaving clothes full of feces in the personal laundry for the family to pick up. Solution: Follow the plan of care and direction. In the documentation a signage stated in part "Your Help is requested to remove feces from clothes, rinse clothes soiled with urine and feces and send soiled clothes to the Oakcrossing Laundry to be washed".

During an interview, Acting Director of Care (Acting DOC) #101 stated, in part, the complainant came a few times complaining about laundry, staff leaving underwear with feces on them. The Acting DOC said that they had asked staff to rinse those before putting it in resident's laundry basket, signage had been put up in the room to remind staff and that "staff should follow the rules". Acting DOC #101 added that staff were not following the plan of care for the resident and they should.

During the observation of resident's room, there were no signage mentioning washing resident's underwear if soiled with feces or urine. A review of the resident plan of care, there were no mention or interventions found in relation to washing resident's underwear if soiled with feces. The interventions were kept in the "Wham Meeting" documentation in the Acting DOC office.

During a separate interview, Acting DOC #101, stated that the signage that they had posted in the resident's room had been removed, acknowledged that there were no mention of interventions in the resident's plan of care and agreed that this could be the reason why staff were still not washing the resident's underwear if soiled with feces.

The licensee failed to ensure that staff and others who provided direct care to a resident kept aware of the contents of the plan of care and given convenient and immediate access to it. [s. 6. (8)]

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 staff and others who provide direct care to a resident kept aware of the contents of the plan of care and given convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response made to the person who made the complaint, indicating what the licensee has done to resolve the complaint.

On a specific date Complaint #IL-73861-LO/Log #001279-20 was submitted to the Ministry of Long Term Care related to care concerns of a resident.

During an interview with the complainant, they stated, they approached staff and management many times in the home to complain about the care of the resident and that it was never resolved.

Review of the home's policy #004100.00 "Response to Complaints" stated, in part, "Policy: It is the policy of PeopleCare that complaints (written or verbal) from residents, families, visitors and staff are investigated and actions are taken for resolution. A response will be made to all complaints within 10 days. If the complaint cannot be resolved within 10 days the complaint will be acknowledged and a date for resolution of the complaint will be given to the complainant."

Review of an internal email from Registered Nurse (RN) #105 to the Administrator dated August 4, 2019, stated, in part, “Subject: [Complainant] concern Laundry. Hi, [complainant] of [resident]. was concerned that staff are putting soiled laundry to resident’s personal laundry bag without cleaning them. This has happened in the past and [complainant] brought forwards this to the management. [Complainant] usually do the laundry for resident but requested, if clothes are soiled with feces sent it to in house laundry or wash the area before putting it to the laundry bag. Discussed with the staff

working this shift. Will have to follow up with rest of the staff working other shifts."

Review of of the home's complaint form dated November 7, 2019, and signed by the Administrator, stated in part "Describe in detail the complaint/concern: Several things – continuity of care nursing staff – not consistent staff. Urine soaked pants x 2 (Again – after previous incident) [resident] to attend events – calendar will be shared.Laundry – continue to have problems – explained that laundry was undergoing a process remain – take time- but we are making hard way. Action taken: continuity of care – Complainant was advised that the home is legislated to support continuity of care – every effort is made to do this in the interest of our residents, esp on Juniper – staff know the residents better than anyone (PSWs) can tell when behaviours are exhibited/responsive – starting- [complainant] was advised that the home will be changing the schedules […] room soaked pants – posters remind staff again. [Resident] is to attend events – calendar – [staff] to review and let me know what [resident] like. Date and Response to complainant : Laundry – doing a review – work in progress. Happy with this. Final resolution. After rec therapy [complainant] happy – events". There were no documented evidence that a response and final resolution had been communicated to the complainant.

During an interview, Acting DOC stated that they did not "close the loop" with the complainant's complaint/concerns and should of responded, found a resolution and contacted the complainant.

The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint. [s. 101. (1) 3.]

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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area.

During an observation of the medication room, called Omnicell, on the second floor of the home, the inspector was able to open a fridge that had a lock containing controlled substances and found 18 vials of Ativan in the presence of a ADOC. The ADOC stated that the fridge door should have been lock and that all controlled substance should be double locked.

The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area. [s. 129. (1) (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On a specific date, Complaints #IL-73494-LO/Log #000402-20 and #IL-73496-LO/Log #000404-20 was submitted to the Ministry of Long Term Care related to medication administration, maintenance and personal support services.

Review of the home's Medication Incidents forms from October 11, 2019 to January 14, 2020, 38 medication incidents were reported. Of the 38 medication incidents the following was revealed:

October 16, 2019: Registered staff found two residents' medication in a bin, medications were not administered;
October 16, 2019: Registered staff found a resident's medication that had not been given;
October 17, 2019: Resident received wrong tube feed which caused minimal harm to resident;
October 31, 2019: Resident received new orders from the hospital and were not processed and resident missed new ordered medication for four days;
November 5, 2019: Registered staff found a resident's medication in package that had not been given;
November 7, 2019: Resident missed medication at 1200 hours;
November 9, 2019: Medication pouch of two residents from November 8 at 2000 hours located in medication cart not administered, signed as given;
November 12, 2019: Registered staff found medication in garbage that was not administered to a resident;
November 12, 2019: Two residents' medication signed on the Electronic Medication Administration Record (eMAR) as given but found in medication cart the next morning;
November 22, 2019: Registered staff found a resident's medication in the cup in the drawer but were signed as given on eMAR;
November 24, 2019: Registered staff reported that a resident went out on a leave of absence with family and were given another resident's medication;
November 27, 2019: Registered staff found a resident's medications but were signed as given on eMAR;
December 19, 2019: Registered staff found a resident's medications but were signed as given on eMAR;
January 5, 2020: Resident was not given morning sliding scale insulin as prescribed;
January 10, 2020: Two medication patches were found on a resident when only one

patch was ordered.

During an interview, Acting DOC stated that medications should have been administered to residents as prescribed by the physician.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On a specific date, Complaints #IL-73494-LO/Log #000402-20 and #IL-73496-LO/Log #000404-20 was submitted to the Ministry of Long Term Care related to medication administration, maintenance and personal support services.

A review of the complaints indicated that medication of residents were left in the residents room and residents were not being monitored while taking their medication.

Review of the home's Medication Incidents forms titled "Hogan Pharmacy Partners LTD" the following was found:

Date of Incident: 2019-10-18;
Description: resident's medications found in resident room still in med cup;
Review of physician's Order: no documentation that resident could self administer medications.

Date of Incident: 2019-10-13;
Description: Family was in for a visit and found white chewed up tabs in resident's room suspecting it was Tylenol. Family was upset that nursing didn't monitor the resident to see that the resident ingested the medication;
Review of physician's Order: no documentation that resident could self administer medications.

Date of Incident: 2020-01-06;
Description: RPN reported staff found a pill on resident dress around 1900 hrs. It was acetaminophen 500 milligrams (mg) x2 tablet. But RPN did not know when resident missed pills;

Review of physician's Order: no documentation that resident could self administer medications.

Date of Incident: 2020-01-13;
Description: Nurse found Perindopril 8 mg in resident's device;
Review of physician's Order: no documentation that resident could self administer medications.

Date of Incident: 2019-12-17;
Description: Nurse found resident's medication in their room not taken.
Review of physician's Order: no documentation that resident could self administer medications.

Date of incident: 2019-11-28;
Description: Nurse found resident's medication in their room not taken. Does not know date that doses would have been missed. All doses on eMAR signed as given;
Review of physician's Order: no documentation that resident could self administer medications.

Observation on January 15, 2020, on third floor, dining room, revealed:
A resident sitting at their table eating, medication left in paper cup with cup of water. No registered staff around.

During an interview, a PSW stated that the medications were the resident's and that the "nurse gives the medication, leave it on the table and comes back to make sure the residents took it".

Observation on a specific date, on the second floor's dining room revealed:
A resident sitting at table with wife, with a plastic cup with what appeared to be apple sauce with a white substance and spoon. No registered staff in the room. A PSW confirmed that it was the resident's medication left on the table.

Review of physician's order for the resident there was no documentation that resident could self administer their medication or could be given by anyone else but the registered staff.

Observation on a specific date, on the third floor's in dining room revealed:
Registered nurse left a plastic cup with medication in front of a resident for them to take.

Observed resident with difficulties taking the medication.

Review of the eMAR for the resident, on day of observation, the resident was given, specific medications for self administration,

Review of the resident's physician's order, the above medications were not the medication that resident was assessed by the physician to self administer.

During interviews, two PSWs reviewed the medication incidents forms and stated that if the medications were found with the residents, that the medications were left unattended and residents were not monitored taking them and should have been.

During an interview, a RPN stated registered staff was to stay with the resident and make sure that they took their medication and if a resident could administer their own medication they had to be assessed and approved by the physician.

During an interview the Acting DOC stated that registered staff should administer and monitor residents when giving their medication unless the resident was assessed and approved to self administer their medication by the physician.

The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber and, that no resident administers a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident, to be implemented voluntarily.

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.