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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2013	2013_217137_0019	L-000460-13	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

MARIAN MACDONALD (137), BARBARA NAYKALYK-HUNT (146), BONNIE MACDONALD (135), RHONDA KUKOLY (213), SHARON PERRY (155)

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 12-16 and August 19-20, 2013

During the course of the inspection, the inspector(s) spoke with Acting Executive Director, Director of Policy and Legislation (Corporate), Chief Operation Officer (Corporate), Acting Director of Resident Care, Acting Associate Director of Nursing, Director of Food Services, Assistant Director of Food Services, 2 Registered Dietitians, Director of Environmental Services, 2 Directors' of Resident Quality Outcomes, Director of Programs, Acting Director of Programs, 2 Recreation Assistants, 1 Recreation Aide, Quality Nurse, Nurse Practitioner, Physiotherapist, 2 Physiotherapy Support Personnel, Social Worker, Office Manager, Nursing Staff Manager, 2 Receptionists, Director of Accommodation Services, Residents' Council President, Family Council President, 3 Registered Nurses, 8 Registered Practical Nurses, 30 Personal Support Workers, 2 Environmental Service Aides, 2 Cooks, 6 Dietary Service Aides, 7 Family Members and 35+ Residents.

During the course of the inspection, the inspector(s) toured the home, observed resident care, dining service, medication administration, activity programs, reviewed residents' clinical records, relevant policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 failed to provide care as set out in the plan of care as evidenced by the following:

A clinical record review revealed an identified resident received fluids beyond the designated fluid restriction amount, 86.6 % of the time, over an identified period. During an interview, the Director of Food Services confirmed her expectation is that resident be provided fluid/day, as specified in the resident's nutritional plan of care. [s. 6. (7)]

2. The recreation leisure plan of care, for an identified resident, indicates the resident will be provided 1:1 contacts and attend activities 3-5 x/week.

Record review, with the Acting Director of Programs, for an identified period of time, revealed the resident's average attendance at activities was 2.6 activities/week and not the 3-5/week, as per the resident's plan of care. Resident has not had any 1:1 recreation activities during the past 3 months..
During interviews with the Director of Programs and Acting Director of Programs, both confirmed their expectation is that resident be provided care as specified in the recreation leisure plan of care. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with as evidenced by the following:

The home's Falls Prevention Management policy, Reference # 005190.00, dated June 18, 2013, states as part of the post falls assessment, #4 initiate a head injury routine if a head injury is suspected and #5-monitor HIR (Head Injury Routine) for 48 hours post falls, for signs of neurological changes.

A record review revealed the Falls Prevention Management policy was not complied with, as an identified resident, was not monitored for 48 hours post falls, using the HIR for signs of neurological changes.
During an interview, the Acting Director of Resident Care confirmed her expectation is that the Falls Prevention Management policy be complied with for 48 hours HIR monitoring, when a resident falls and sustains a head injury. [s. 8. (1)]

2. The home's MRSA policy, reference # 008030.00(e), dated 2012/04/09, states as part of the communication section that the Infection Control Practitioner will be notified within 24 hours of all newly identified residents with MRSA. The resident's chart will be flagged to identify the status. This will also be identified in their Point Click Care (PCC) chart.
A record review, for two identified residents, revealed there was no documented evidence indicating MRSA status or the reason for isolation.
The Acting Director of Resident Care confirmed that the above was not noted and it is the expectation that the reason for isolation is recorded in the PCC allergy section of the chart.

The home's Tuberculosis Screening and Mantoux Testing policy, Reference # 003050.00 states that "recording of negative, doubtful or positive are not acceptable. Induration in mm must be indicated".
For three identified residents, TB test results were all recorded as negative.
The Acting Director of Resident Care confirmed that the results are not recorded in mm, as per the home's policy. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment as evidenced by:

A record review, for an identified resident, revealed that weekly wound assessments were not conducted.
The Acting Associate Director of Nursing confirmed that weekly wound assessments are an expectation and that they were not being completed, for the identified resident. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality as evidenced by:

- During lunch service, August 12, 2013, in the Juniper dining room, the minced Vegetarian Lasagna was observed to be "soup like" in texture.
- August 14, 2013 in White Pine Dining room, the minced plums served at lunch and the minced apricots served at dinner were observed to be very fine in consistency, with particle size of 1/8 inch or less.
During an interview, the Director of Food Services confirmed, the minced vegetarian lasagna, minced plums and minced apricots were not the correct consistency, for the minced diet.

The home's Dietary policy, Minced Diet Guidelines, Reference # 104080.00 (a) August 17, 2012, was reviewed and it states that minced textured foods are ground or minced to a particle size of ¼ inch (6mm).

The Director of Food Services confirmed her expectation is that minced foods are not "over processed" and are prepared using methods which preserve nutritive value or appearance and are ground to a minimum particle size of 1/4 inch (6mm), as per the home's policy. [s. 72. (3) (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 that all foods and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The home failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents as evidenced by:

Interviews with residents revealed that breakfast is good, lunch is okay but dinners, including vegetables are cold, not palatable and potatoes are hard.
Concerns regarding the food have been brought forward to Residents' Council. [s. 73. (1) 6.]

2. A review of the Food Committee minutes, of October 5, 2012, revealed that hot foods were cold too quickly, that soup is cooled off and the plates were cold.
A review of the Family Council minutes , of February 11, 2013, revealed that residents complained that food is cold when served.
A review of the Food Committee minutes, of March 6, 2013, revealed that tables served, near the end of the meal service, received cold food. [s. 73. (1) 6.]

3. The licensee failed to ensure a resident was provided with an assistive device, required to safely eat and drink as comfortably and independently as possible as evidenced by:

An identified resident was observed being fed with a tablespoon. The staff member shared that there were no more assistive devices available in the dining room. According to the resident's plan of care, adaptive devices are to be provided to maintain an adequate level of functioning. [s. 73. (1) 9.]

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 providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and to ensure food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the infection prevention and control program must include measures to prevent the transmission of infections, as evidenced by:

There are no contact precaution isolation signs posted on the bedroom doors for three identified residents.
For another identified resident, there is no contact precaution isolation sign posted on the bedroom door and there is no infection control cart, containing Personal Protective Equipment (PPE), located at the entrance to the room.
The Acting Director of Resident Care confirmed that contact precaution isolation signs are to be posted and PPE available. [s. 86. (2) (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 infection prevention and control program must include measures to prevent the transmission of infections, to be implemented voluntarily.

WN #7: 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 participate in the implementation of the infection prevention and control program as evidenced by:

The home was not aware that an identified resident had been diagnosed with an infection, until it was brought to the attention of the home on August 19, 2013, by Inspector #155, although there was documentation on the chart confirming the infection. [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 #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure the home is a safe and secure environment for its residents as evidenced by:

Two footrests were observed on a shelf, in the main lobby of the home, on August 13, 2013.
Two footrests were observed on a chair, in the Sugar Maple dining room, on August 14, 2013.
The Executive Director confirmed that the footrests should not have been there, as they can pose a safety risk. [s. 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system could be easily accessed and used by residents, staff and visitors at all times as evidenced by

An interview and a record review, revealed that an identified resident has weakness and unable to activate the bathroom call bell independently.
The nurse confirmed that the resident does sometimes go to the washroom independently, without staff awareness, resulting in the resident not being able to activate the call bell. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The Licensee failed to ensure to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results as evidenced by:

During an interview, a representative of the Residents' Council was unable to recall being involved in the development of the satisfaction survey or of seeing the results of the satisfaction survey.
During an interview, with the Residents' Council Staff Assistant, on August 14, 2013, it was confirmed that the Residents' Council was not advised and consulted about the development and results of the satisfaction survey. [s. 85. (3)]

2. The licensee failed to seek the advice of the Family Council in developing and carrying out of the resident satisfaction survey, and in acting on its results, as evidenced by:

During an interview, a representative of the Family Council confirmed that the Family Council had not been asked to provide input into the development of the home's satisfaction survey.
The Acting Executive Director confirmed the home did not seek the Family Council advice in the development of the current satisfaction survey and it is the expectation that, in future surveys, the home will seek the advice of the Family Council, in the development and carrying out of the satisfaction survey, and acting on its results. [s. 85. (3)]

3. The Licensee failed to ensure that the results of the satisfaction survey are documented and made available to the Residents' Council and Family Council, to seek their advice, as evidenced by:

The Executive Director shared that the satisfaction survey results were received by the home in June 2013 and confirmed that, to date, the results have not been documented and made available to the Residents' and Family Councils. [s. 85. (4) (a)]

WN #11: 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 failed to ensure that drugs are stored in compliance with manufacturer's instructions as evidenced by:

During an observation of the White Pine Medication Room Storage cupboard, it was observed that 14 bottles of Acetaminophen 325 mg had an expiration date of April 2013 and 7 bottles of Acetaminophen 325 mg had an expiration date of May 2013. This was confirmed by the Registered Practical Nurse (RPN). [s. 129. (1) (a)]

WN #12: 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. (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 failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation to the resident as evidenced by:

Medication was observed on the bedside table of an identified resident. There was no documented evidence of a physician's order for self-administration of the medication and this was confirmed by the Registered Practical Nurse. [s. 131. (5)]

Issued on this 5th day of September, 2013

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

Marian C. Mac Donald