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
Dec 20, 2021	2021_834524_0009	015982-21, 015994-21, 018067-21, 018503-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

McGarrell Place
355 McGarrell Drive London ON N6G 0B1

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

INA REYNOLDS (524)

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): December 6, 7, 8, 9, 10 and 13, 2021.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS # 2964-000042-21 / Log # 015982-21 related to responsive behaviours and prevention of abuse
CIS # 2964-000043-21 / Log # 015994-21 related to falls prevention and management
CIS # 2964-000050-21 / Log # 018067-21 related to responsive behaviours and prevention of abuse
CIS # 2964-000052-21 / Log # 018503-21 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Nurse Manager, Registered Nurses, a Registered Practical Nurse, Personal Support Workers, a Housekeeping Aide and residents.

The inspector(s) also conducted a tour of the home and observed resident care provisions and resident rooms, staff to resident interactions, infection prevention and control practices, and reviewed clinical healthcare records for identified residents.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #003 that sets out clear directions to staff and others who provided direct care to the resident.

The Ministry of Long-Term care received a critical incident system (CIS) report related to an incident of abuse by resident #003 towards co-resident #004. Record review showed that resident #003 had a history of responsive behaviour directed towards other residents and staff due to a specific diagnosis.

The care plan in Point Click Care (PCC) included identified triggers and specific actions for staff to follow.

Personal Support Worker (PSW) #105 said they were aware of the care needs of resident #003 through the Point of Care (POC) Kardex or in the Behaviour Support Ontario (BSO) binder. Review of the Kardex and the BSO binder showed the triggers and interventions were not included in these documents. This was verified by Nurse Manager (NM) #104. NM #104 acknowledged that the PCC plan of care and POC Kardex were not consistent as these responsive behaviour interventions and triggers were not linked to the Kardex. Not providing clear direction to the PSW's related to resident #003's responsive behaviour interventions and triggers placed other residents at risk of harm.

Sources: Critical Incident System report; resident #003's clinical records; and, interviews with NM #104, PSW #105 and other staff. [s. 6. (1) (c)]

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 resident #003 that sets out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

Issued on this 23rd day of December, 2021

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

Original report signed by the inspector.