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
Mar 1, 2022	2022_834524_0005	017097-21, 018294-21, 018475-21, 018872-21, 002682-22	Critical Incident System

Licensee/Titulaire de permis

The Women's Christian Association of London
2022 Kains Road London ON N6A 0A8

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

McCormick Home
2022 Kains Road London ON N6K 0A8

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

INA REYNOLDS (524), TATIANA PYPER (733564)

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): February 22, 23 and 24, 2022.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS # 2965-000028-21 / Log # 017097-21 related to medication management
CIS # 2965-000030-21 / Log # 018294-21 related to falls prevention and management
CIS # 2965-000031-21 / Log # 018475-21 related to falls prevention and management
CIS # 2965-000034-21 / Log # 018872-21 related to maintenance
CIS # 2965-000001-22 / Log # 002682-22 relate to hospitalization and change in condition.

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

The inspector(s) also observed resident rooms and common areas, the kitchen area, infection prevention and control practices within the home, residents and the care provided to them, reviewed clinical healthcare records and plans of care for identified residents, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services

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

- **3 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	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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment with respect to a resident's provision of a specific treatment.

Review of a critical incident documented that a family member was concerned and reported that a resident was having difficulties. A registered nurse then assessed the resident and found the resident was not receiving a specific treatment. The resident had an order for a specific treatment with defined parameters. The resident was sent to hospital for assessment.

Review of the resident’s plan of care showed there was no focus statement, goals or interventions with respect to the resident's provision of a specific treatment. Interventions were also not included in the Kardex or on the Point of Care (POC) task list for documentation by Personal Support Worker (PSW) staff. The home's policy stated that for residents on this specific treatment, the procedure was to assign this to the POC task, and the personal support worker would sign the POC tasks every shift.

A Registered Practical Nurse (RPN) and a PSW verified that staff would use the Kardex and POC to follow resident care interventions. A PSW said that specific tasks were to be completed and monitored for residents on this specific treatment and documented on every shift.

The Director of Care (DOC) reviewed the clinical record and acknowledged that the specific treatment was not included in the resident’s plan of care and monitoring of the specific treatment was not assigned on the POC task and should have been.

There was a risk to resident as they were not receiving the specific treatment as ordered at the time of the incident.

Sources: Critical Incident System report; the home’s policy; the resident’s clinical records; and interviews with the DOC, RPN, and PSW. [s. 26. (3) 18.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment with respect to the residents provision of a special treatment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Review of a critical incident documented a resident fell from a mechanical lift during a transfer. This resulted in an injury and the resident was transferred to hospital for assessment.

Two personal support workers (PSWs) were present for the transfer. A PSW said they had not used the proper method when positioning the sling for the resident and the resident had slipped from the sling.

Record review documented that the resident required a mechanical lift and two staff for transfers and used a specific device for mobility with full staff assistance.

The DOC and the Physiotherapist both said staff should have used a specific method when positioning the sling for the resident. The DOC acknowledged the two PSWs had not used safe transferring and positioning techniques when assisting the resident.

As a result of the improper transfer there was actual harm to the resident, as they sustained injuries and required a transfer to hospital for assessment.

Sources: Critical Incident System report; the resident's clinical records; and interviews with the DOC, a PSW, and a Physiotherapist. [s. 36.]

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 use safe transferring and positioning techniques when assisting a resident, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

Review of a critical incident documented that a resident had a specific medication order related to their diagnosis. The order instructed registered staff to follow a particular procedure prior to giving the medication and to hold the medication if measures fell within specific defined parameters.

Progress notes documented that on a specific date, the medication was administered in error. A Registered Nurse (RN) verified they had administered the medication and had not completed the procedure prior to giving the medication. The RN said they noticed the instruction on the electronic Medication Administration Record (eMAR) after they gave the medication. The resident was subsequently transferred to hospital for assessment.

The Director of Care (DOC) said the registered staff did not read the order on the eMAR to hold the medication if specific parameters were met. The DOC said that a step was missed to complete the specific procedure, and the medication should have been held.

There was an actual risk to the resident when their medication was not administered in accordance with the directions for use specified by the prescriber.

Sources: Critical Incident System report; Silver Fox pharmacy Incident report; the resident’s clinical records; and interviews with the DOC and RN.
[s. 131. (2)]

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 the residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 1st day of March, 2022

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

Original report signed by the inspector.