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
Direction de l'amélioration de la performance et de la conformité

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 26, 2015	2015_276537_0007	L-001807-15	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

NANCY SINCLAIR (537), ALI NASSER (523), REBECCA DEWITTE (521)

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): February 2,3,4,5,6,9,10,11, 12, 2015

Log #001448-15/CIS 2980-000005-15 and #010095-14/CIS 2980-000064-14 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with 40 Residents, 3 Family Members, the Executive Director, Director of Care, 2 Assistant Directors of Care, Environmental Service Manager, Director of Programs, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Maintenance Staff, 2 Recreation Aides, 2 Housekeeping Staff, 2 Registered Nurses, 7 Registered Practical Nurses, and 10 Personal Support Workers.

The inspector(s) also toured the home, observed meal service, a medication pass, medication storage areas, recreational activities and care provided to residents, reviewed health records and plans of care for identified residents, reviewed assessments, policies, procedures, and related training records, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **8 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the every resident was afforded the right to privacy in treatment.

An identified resident was observed being provided a medication in the dining area at the dining table.
The Registered Staff confirmed it was the home's expectation to ensure the Resident was afforded the right to privacy in treatment. [s. 3. (1) 8.]

2. The licensee has failed to ensure that every resident was afforded the right to have his or her personal health information kept confidential.

On two occasions, the eMAR terminal on the medication cart was observed to be left unlocked and unattended, revealing resident personal health information.
The Registered Staff verified the terminals should be locked when unattended and it is the home's expectation that all personal health information is to be kept confidential.

On two occasions, the Health Records Room where resident charts are stored, was observed to be unlocked and unattended.
The Director of Recreation and Registered Staff verified the rooms were unlocked, that the Health Records Room should be locked when unattended, and confirmed it is the home's expectation that all personal health information is to be kept confidential.

A full disclosure of a medical diagnosis was given to a resident during the medication pass in a dining area. The Registered Staff explained the purpose of the medication to the resident including disclosure of a medical diagnosis. The three other residents at the table heard the description of the resident's medical diagnosis.
The Registered Staff confirmed it is the home's expectation that all personal health information is to be kept confidential.

Observations of the Therapeutic Services room revealed the door was unlocked and unattended with Resident Dental assessments and treatment plans on the counter, revealing personal health information of residents.
The Assistant Director of Care confirmed that the room was unlocked and unattended, and it is the home's expectations that all personal health information is to be kept confidential. [s. 3. (1) 11. 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 the rights of residents are fully respected and promoted that every resident has the right to be afforded privacy in treatment and in having his or health personal health information kept confidential, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions is documented.

Record review for an identified resident indicates an area of altered skin integrity with a corresponding order for assessment and documentation.

Review of the home's policy, Skin and Wound Management Program, Reference No. 006020.00, Date Effective 2014/10/01, indicates the following:
Registered Staff will:
4. Assess each resident with skin breakdown weekly or more frequently, if needed and complete documentation in PCC.

Review of the Treatment Administration Records (TAR) indicate that the ordered treatment protocol has been signed off by various registered staff.

Review of the Resident Clinical Record identifies that the area of altered skin integrity was signed off as being assessed with no corresponding supporting documentation in Point Click Care (PCC) notes on several occasions in an identified time period.

The Director of Resident Care and The Assistant Director of Care/Skin and Wound Nurse verified that there was no documentation on the identified dates and that the expectation would be that there would be corresponding documentation in PCC outlining the results of the assessment that had been signed off. [s. 30. (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 any actions taken with respect to a resident under a program , including assessments, reassessments, interventions and the resident's response to interventions is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint by a physical device was included in the plan of care.

A record review for an identified resident revealed the use of a restraint by a physical device was not included in the plan of care.

An interview with the Registered Staff confirmed the use of the physical restraint for the resident was not in the plan of care and it was the home's expectation that the restraint by a physical device was to be included in the plan of care. [s. 31. (1)]

2. The licensee has failed to ensure that the restraint by a physical device plan of care included an order by a physician or a registered nurse in the extended class.

A record review for an identified resident revealed the plan of care for the use of a restraint by a physical device failed to include an order by a physician or a registered nurse in the extended class.

The Registered staff confirmed there was no order for the restraint and it was the home's expectation that all restraints have an order by a physician or a registered nurse in the extended class. [s. 31. (2) 4.]

3. The licensee has failed to ensure that where the resident is restrained by a physical device that the resident is monitored in accordance with the requirements provided in the regulations.

A record review for an identified resident revealed the use of a restraint by a physical device without any documented monitoring every hour while the restraint was in place.

An interview with the Registered Staff confirmed there had not been hourly monitoring while the identified restraint was in place.

The Administrator confirmed it was the home's expectation that all restraints are monitored every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff. [s. 31. (3) (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 restraint by a physical device includes an order by a physician or a registered nurse in the extended class, is included in the resident's plan of care, and is monitored in accordance with the requirements provided in the regulations, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the 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.

Observation of an identified resident revealed an area of altered skin integrity. Interviews from staff providing the resident with care revealed no knowledge of how or

when the resident experienced the area of altered skin integrity.
A record review revealed no documentation using a clinically appropriate assessment instrument had been completed for the area of altered skin integrity.

The Director of Care confirmed it was the home's expectation that an area of altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record Review for and identified resident indicates an alteration in skin integrity, with a corresponding order for treatment and assessment.

Review of the home's policy, Skin and Wound Care Management, Reference No. 006020.00, Date Effective: 2014/10/01 indicates the following:
Registered Staff will:
4. Assess each resident with skin breakdown weekly or more frequently, if needed and complete documentation in PCC.

Review of the Treatment Administration Records (TAR) and the Point Click Care (PCC) documentation indicates that the area was not assessed weekly and there was no corresponding documentation of an assessment in Point Click Care.

The Director of Resident Care and the Assistant Director of Care/Skin and Wound Nurse verified that there was not a weekly assessment recorded in the Treatment Administration Record (TAR) and corresponding documentation in Point Click Care (PCC).

The Director of Nursing confirms that it is the home's expectation that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff. [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 the 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, 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On two occasions, dining room observations revealed identified residents being fed by staff while standing.

The staff in the dining areas confirmed they were standing and it was the home's expectation for staff to be seated using proper techniques to assist residents with eating.
[s. 73. (1) 10.]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the required assistance.

On two occasions, observations during dining revealed an identified resident had been served a meal without someone being available to provide the assistance required. The meal was on the table for ten minutes before assistance was provided.
This was verified by staff who confirmed it is the home's expectation that the food is served to residents who requires assistance with eating or drinking only when someone is available to provide the assistance.
[s. 73. (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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance and to ensure that Residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

Observations of a medication pass revealed a prepoured narcotic medication in the drawer of the medication cart.

The Registered Staff verified the medication had been prepoured and confirmed it was the home's expectation that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident. [s. 126.]

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 remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident, to be implemented voluntarily.

WN #7: 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 drugs are stored in an area or a medication cart that is secure and locked.

Observations revealed the medication cart was left unlocked while the Registered Staff gave the residents their medications. Residents travelled past the unlocked medication cart.
Observations revealed the medication cart in a hallway was unlocked while the Registered Staff went into a resident room to administer medications.
The Registered Staff verified the medication cart was unlocked and confirmed it was the home's expectation that the drugs are stored in a secure and locked medication cart.

Observations revealed medications were left on the top of the medication cart and unattended during the medication pass.
The Registered Staff verified the medications were left out and unattended and confirmed it was the home's expectation to store the medications in the locked medication cart. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #8: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Observations during the medication pass revealed the Registered Staff did not complete hand hygiene during the administration of medications to residents.
This was verified by the Registered Staff who confirmed it was the home's expectation that hand hygiene would be completed during medication administration as part of the implementation of the infection prevention and control program.

During stage 1 of the Resident Quality Inspection, observations revealed resident wash basins, urinals and bedpans were stored on the floor identified bathrooms.
An interview with the Director of Care revealed it was the homes expectation that the wash basins, urinals and bedpans were not to be stored on the floor for the infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: 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 has failed to ensure that the home is a safe and secure environment for its residents.

Observation revealed that the Therapeutic Services Room was unlocked and unattended with potentially harmful items.

The room is located in an area that is accessible to residents. The inspector found the room unlocked and unattended for greater than 10 minutes until a staff member returned.

The Assistant Director of Care (ADOC) confirmed that the expectation is that the home be a safe and secure environment for its residents. [s. 5.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

Observations of identified rooms on the second and third floor in the home revealed that once the tilt latches of the windows are pushed in, the window will open 107 centimetres, creating an opening of 77x70 centimetres. Stoppers are in place to limit sliding windows up or down no more than 15 centimetres.

A tour with the Environmental Services Manager to the third floor common areas and sample rooms confirmed that the window can tilt in and fully open. The Environmental Services Manager confirmed that all the windows in the home open the same way except the secure area where the latches are screwed in.
The Administrator stated that the windows were approved by the Ministry's preoccupancy inspections but regardless of that the home is already in the process of securing all windows.

The Administrator confirms that it is the expectation that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres. [s. 16.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's desired bedtime routine is supported.

Review of the plan of care for an identified resident revealed that the resident has a preferred time to wake up and go to bed. Interview with day staff revealed that the resident was awakened earlier than the preferred time. Interview with evening staff confirmed that staff put the resident to bed earlier than the preferred time.

This was confirmed with the Administrator and Director of Care that the home's expectation is that a resident's bedtime routine is individualized and supported. [s. 41.]

Issued on this 26th day of March, 2015

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

Original report signed by the inspector.