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
Jan 9, 2014	2014_183135_0003	L-001036-13	Complaint

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

BONNIE MACDONALD (135)

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 7, 2014.

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Director of Food Services, Registered Practical Nurse, Two Personal Support Workers, Dietary Aide and Resident.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, policy and procedures, interviewed staff and resident and observed lunch service in resident home area.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 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 ensure that the care set out in the plan of care was provided as specified in the plan when the following occurred:

Resident at high nutritional risk had a new diet order, stating "if resident doesn't eat during mealtime and when meals are refused resident is to receive 237 mls. of the nutritional supplement Boost 1.5.

Record review from December 6, 2013, to January 6, 2014, revealed that the resident had refused a meal on the following occasions:

December 11, 2013
December 15, 2013
December 20, 2013
December 21, 2013
December 26, 2013

Review of the home's Medication Administration Records (MAR) revealed that the resident had not received the nutritional supplement Boost on 5 occasions, when resident had refused meals in December 2013.

During an interview the Director of Care confirmed her expectations that care set out in the plan of care be provided as specified in the plan related to residents receiving their nutritional supplements. [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 ensuring that the care set out in the plan of care is provided related to residents receiving their nutritional supplements, 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 has failed to ensure that home's Abuse or Suspected Abuse/Neglect of a Resident Policy # 005010.00 October 23, 2012, was complied with when the following occurred:

Home's policy for investigation and interventions of abuse states, assess the situation and #3-obtain written statements from all witnesses and document his/her account of the incident using the incident Report form.

The Assistant Director of Care (ADOC) was notified about abuse of a resident.The resident no longer wanted the staff member to provide care.

The ADOC, met with the staff member regarding the incident.

During interview with the ADOC, she confirmed that there were no written statements from the staff member or any witness of the incident, nor did the ADOC document her account of the incident using the Incident Report form.

During an interview, the Director of Care confirmed her expectation that the home's Abuse or Suspected Abuse/Neglect of a Resident Policy be complied with when resident abuse has been reported. [s. 8. (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 ensuring the home's Abuse or Suspected Abuse/Neglect of a Resident Policy be complied with when resident abuse has been reported, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion of the investigation when the following occurred:

The Assistant Director of Care (ADOC) was notified by resident's SDM regarding abuse/neglect of a resident.

The ADOC met with the staff member regarding the incident.

As of January 7, 2014, the ADOC confirmed she had not notified the resident's SDM of the results of the alleged abuse or neglect investigation immediately upon the completion of her investigation.

During an interview the Director of Care confirmed her expectation that the resident and resident's SDM are notified of the results of any alleged abuse or neglect investigation immediately upon the completion of the investigation [s. 97. (2)]

Issued on this 9th day of January, 2014

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