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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 14, 2017	2017_636634_0016	024008-17	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

ADAM CANN (634), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 27 and 30, 2017.

The following inspections were conducted concurrently during this inspection:

Log # 023475-17, IL-53404-LO, related to falls prevention and management, sufficient staffing, and medications.
Log # 004869-17, CIS # 2980-000005-17, related to falls prevention and management.
Log # 001751-17, CIS # 2980-000002-17, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Corporate Director, Director of Resident Care, Assistant Director of Care, Maintenance Manager, Director of Resident Quality Outcomes, Residents' Council member/ Family Council member, five Registered Nurses, three Registered Practical Nurses, nine Personal Support Workers, one Housekeeper, three family members, residents of the home, and one Environmental Services Worker.

The inspector (s) conducted a tour of the home, reviewed clinical records, and plans of care for relevant residents, pertinent policies and procedures, Residents' Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration, and Ministry of Health and Long Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing

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	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

A complaint related to staffing shortage and residents missing their baths was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by a family member of a resident.

In stage one of the Resident Quality Inspection (RQI), a resident stated that they preferred a tub bath and they missed having their baths like when they were at their own home.

The policy "005230.00 Hygiene, Personal Care and Grooming" last reviewed January 31, 2017, stated that "resident's will be offered and receive a tub bath or shower twice weekly or as per their preference" and "the PSW will document bathing on the resident's task bar in Point of Care (POC).

In interviews with Personal Support Workers (PSW's) and a Registered Nurse (RN), they said that the expectation was that all residents would receive two baths weekly, and they document resident bathing in POC. The PSW staff also stated that the POC

documentation included if the resident received their bath, refused, or was away from the home or unavailable. The PSW's further stated that they would inform the Registered Nurse (RN) if a bath was missed and the RN would inform management so that the missed bath could be made up.

The POC tasks “60-day look back for question one bathing” showed the following:

-There was no documented bath or refusal for three residents on multiple occasions.

In an interview with one of the resident's, they said that they missed baths at their scheduled time but these baths were made up. The resident stated that they received a tub bath twice weekly.

In an interview with another resident, they were unable to recall if they had missed their bath.

In an interview with a third resident, they stated that they usually had two baths weekly and occasionally they had missed their scheduled bath on a specified day of the week. The resident could
not recall if they had received a bath the next day instead.

In an interview with Director of Resident Care (DOC), they agreed that it was unclear if the residents received their bath on their scheduled day or on the next day. The DOC also agreed that the POC documentation related to resident's baths were not completed and should have been.

The licensee has failed to ensure that the provision, outcome and effectiveness of care were documented related to resident's bathing. [s. 6. (9)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

During the Resident Quality Inspection (RQI), a resident was reviewed for falls prevention related to a fall the resident had sustained.

Observation conducted revealed a fall mat was located on the floor beside the resident's bed.

Review of the resident's plan of care revealed the fall mat was not in the plan of care.

Interview was completed with a Personal Support Worker (PSW), who reviewed the resident's plan of care and stated the fall mat was not documented in the plan of care.

Interview was completed with Director of Resident Quality Outcomes who was shown the fall mat and stated if the fall mat was to be used, the expectation was that it was included in the resident's plan of care.

Interview completed with Director of Resident Care (DOC) who stated that they had reviewed the use of the fall mat and stated it should have been included in the resident's plan of care but was not.

The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

The severity of this non-compliance was a level one, minimum risk and the scope was widespread. The home does not have a history of previous related non-compliance. [s. 6. (10) (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 plan of care set out clear directions to staff and others who provide direct care to the resident, and to ensure that the provision, outcome and effectiveness of care are documented, to be implemented voluntarily.

Issued on this 8th day of January, 2018

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

Original report signed by the inspector.