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
Jun 28, 2018	2018_263524_0009	010101-18	Resident Quality Inspection

Licensee/Titulaire de permis

peopleCare Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

INA REYNOLDS (524), CASSANDRA ALEKSIC (689), JOANNA WHITE (727), JULIE LAMPMAN (522), NANCY SINCLAIR (537)

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): June 11, 12, 13, 14, 15, 18, 19, 20, 21 and 22, 2018.

The following intakes were completed within the Resident Quality Inspection:
Log #009697-18 / Complaint #IL-56911-LO related to Falls Prevention

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Administrator, the Director of Resident Care, the Assistant Director of Resident Care, the Resident Assessment Instrument Coordinator, the Director of Environmental Services, the Director of Accommodation, the Social Worker, the Assistant Director of Food Services, one Registered Dietitian, Pastoral Care staff, one Registered Nurse, nine Registered Practical Nurses, twenty Personal Support Workers, one Cook, two Dietary Aides, one Recreation staff, one Laundry Aide, the Residents' Council Representative, the Family Council Representative, residents and family members.

The inspector(s) also conducted a tour of the home, observed resident care provisions, resident and staff interactions, dining services, medication administration, a medication storage area, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home. Inspectors reviewed residents' clinical records, postings of required information, relevant meeting minutes, education records, medication incident reports, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **5 WN(s)**
- **4 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. (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).

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 has failed to ensure that the written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection an identified resident expressed concern that a Personal Support Worker (PSW) was rough with the resident.

In an interview on a specific date, the resident also told the inspector that after they had an accident on a specific date, a PSW had come into their room and took their clothes and put them in two bins and said they had to go in the wash. The resident stated they did not want the PSW to do this but the PSW did it anyway. The resident stated the PSW told them later that they would do it again. The resident stated the PSW spoke with them in a harsh manner. The resident stated they had told a specific Registered Practical Nurse (RPN) what had happened.

In an interview on a specific date, the RPN stated they did not remember a particular occasion and stated the resident had a specific behaviour and provided an example of the behaviour. The RPN stated they had a good rapport with the resident and they would normally speak with the resident if staff indicated they were having difficulty related to the identified behaviour.

The inspector asked the RPN if there were interventions in the resident's care plan related to the resident's behaviours. The RPN stated they were sure there were interventions in the resident's care plan related to this.

A review of the resident’s most recent care plan with the RPN noted no focus or interventions related to the resident’s specific identified behaviour.

In an interview on a specific date, the Assistant Director of Resident Care (ADRC) stated they would expect interventions related to the resident's behaviour to be included in their plan of care.

The licensee has failed to ensure that the written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) The Ministry of Health and Long-Term Care received a complaint on a specific date, which included a concern related to falls prevention, and transferring and positioning techniques for an identified resident.

In an interview with the complainant on a specific date, the complainant said that a Personal Support Worker (PSW) had transferred the resident onto an identified personal care device. They said the PSW left the resident on the personal care device unattended. The complainant said they spoke with the PSW, stating that the resident was at risk for falls and was not to be left unattended. They said that the staff did not follow the direction in the resident's care plan, and that the resident was not to be left alone on the personal care device.

The care plan in Point Click Care (PCC) with a specific revision date for the resident stated the resident required extensive assistance with transfers.

Review of the Fall Risk Screening and Post Fall Assessment for a specific date, stated that the resident tried to transfer themselves from a identified personal care device to the bed and lost their balance and fell. The fall was unwitnessed according to the assessment.

Review of tasks in the "Follow-Up Question Report” for a specific period of time showed under the identified tasks, that the resident should not be left unattended on the personal care device.

In an interview with a Personal Support Worker (PSW) on a specific date, the PSW said

that they assisted the resident with a personal care task on a specific date. The PSW said that they, along with another PSW, had left the resident unattended, with call bell in reach, to assist another resident across the hall. The PSW said they checked in on the resident, but the resident was not finished with their personal care task at that time. The PSW said that they informed other staff on duty that they needed to check on the resident right away and the PSW went on break.

In an interview with the Administrator on a specific date, the inspector identified the specific tasks which stated that the resident should not be left unattended on the personal care device. When asked what their expectations were regarding staff to follow the tasks and care plan, the Administrator said that they would expect that the resident would not be left unattended on the personal care device.

b) During stage one of the Resident Quality Inspection an identified resident expressed concern that a Personal Support Worker (PSW) was rough with them. The resident stated they had an accident with an identified injury on a specific date. A PSW came to help them with their exercises and the PSW had hurt the resident's injured area. The resident stated they had asked a Physiotherapist (PT) why they had asked the PSW to do the exercises with them.

Review of the resident's progress notes, physician orders and the resident's Treatment Administration Record (TAR) in Point Click Care identified specific exercises for the resident. The order indicated this was not a delegated task and only to be completed by a registered staff on every identified shift.

In an interview on a specific date, the PSW stated they had supervised the resident with their exercises after the resident had an injury. The PSW stated that after the resident complained they no longer assisted the resident with the exercises.

In an interview on a specific date, a Physiotherapist (PT) stated that the resident told them a PSW had hurt their injured area when the PSW was helping the resident with their exercises. The PT stated they had written the exercises along with the Registered Practical Nurse in the resident’s TAR. The PT stated the exercises were to be completed by registered staff and that was why they were written as an order in the TAR. The PT stated that they had not taught the exercises to the PSWs and they should not have been assisting the resident with their exercises. The PT stated once they became aware that the PSW had assisted with the exercises they spoke with the Assistant Director of Resident Care (ADRC) and the order was rewritten to ensure only registered staff

completed the exercises.

In an interview on a specific date, the ADRC stated that the PSW should not have assisted the resident with their exercises as they were not trained on how to complete the exercises.

The licensee has failed to ensure that the care set out in the plan of care was provided to the identified residents as specified in the plan. [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 to ensure that the written plan of care for the resident set out clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

The Long-Term Care Homes Act, 2007 defines staff as, "Persons who work at the home, pursuant to a contract or agreement with the licensee."

In an interview on a specific date, a Physiotherapist (PT) from an agency, who worked at the home stated they were pretty sure they had read something on abuse and neglect but could not remember if it was through the agency or through peopleCare.

In an interview on a specific date, the Executive Director of Resident Care (EDRC) confirmed that this specific agency had staff working in the home and that the PT had completed training on abuse and neglect. The ERDC stated the company also had an Occupational Therapist (OT) that worked in the home and confirmed that the OT had not received training from peopleCare on abuse and neglect prior to working in the home as the OT only worked on specific days.

In an interview on a specific date, the Administrator indicated that all staff should receive training on abuse and neglect.

The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

2. The licensee has failed to ensure that all staff had received retraining annually related to the following: the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and, the whistle-blowing protections.

A review of the home’s training records on abuse and neglect for 2017 noted that 40 out of 184 (21.7 per cent) employees had not completed training on abuse and neglect.

In an interview, the Executive Director of Resident Care (EDRC) confirmed that not all staff had completed training on abuse and neglect in 2017. The ERDC stated that the home had received a voluntary plan of correction from the Ministry of Health and Long-Term Care earlier in 2018 for not completing training for all staff on abuse and neglect in 2017.

The inspector asked the ERDC to see the training records for those staff who had not completed training on abuse and neglect in 2017. Currently six out of 40 (15 per cent) of those staff had still not completed training on abuse and neglect.

In an interview on a specific date, the Administrator stated that mandatory training on abuse and neglect was completed annually in March. The Administrator stated that the staff that had not completed training on abuse and neglect should have completed the training when it was identified that they had not completed it in 2017, and that their training should be completed immediately.

The licensee has failed to ensure that all staff had received retraining annually relating to the following: the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and, the whistle-blowing protections. [s. 76. (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 receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities; and, to ensure that all staff receive retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted within six months before a staff member was hired by the licensee.

A review of pre-screening of four random employees and a volunteer hired within the past four months noted the following:
-a Personal Support Worker with a specific hire date, had a police check on file that was dated seven months prior to the date of hire.
-a Pastoral Care staff with a specific hire date did not have a police check on file. A receipt from London Police with a specific date, indicated that a police check had been paid for and was on file.

In an interview on a specific date, the Executive Director of Resident Care stated that both staff were currently working. In an interview on a specific date, the Administrator stated that staff should have a police check completed six months before they start work.

The licensee has failed to ensure that a criminal reference check was conducted within six months before a staff member was hired by the licensee. [s. 215. (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 a criminal reference check is conducted within six months before a staff member is hired by the licensee, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift the symptoms of infection for residents were recorded.

a) During stage one of the Resident Quality Inspection, an identified resident was noted as having a respiratory infection from the Minimum Data Set (MDS) Assessment.

Review of the Quarterly MDS Assessment completed for the resident on a specific date, noted that the resident had a respiratory infection.

Review of the "Respiratory Line Listing" for outbreak on a specific date, showed symptoms of infection for the resident, with a recorded onset date and an outcome isolation completion date.

In an interview on a specific date, a Registered Practical Nurse (RPN) stated staff monitor symptoms of infection in residents every shift and document this in an Infection Follow up note in Point Click Care (PCC).

The home's policy titled "Surveillance and Process of Data Collection" reference number 004020.00, stated the following: "Relevant infection prevention and control information will be documented in the resident's progress notes in PCC (e.g. date of isolation) by the frontline care provider(s) and/or the Infection Control Practitioner".

Record review of the resident's progress notes on PCC for a specific date range showed that 12 out of 23 (52 per cent) shifts did not have documentation of the symptoms of infection for the resident.

In an interview on a specific date, the Assistant Director of Resident Care (ARDC) reviewed the resident's progress notes with the inspector. The ARDC stated that all registered staff should have completed an Infection Follow up note for the resident on every shift for the specific date range.

b) During stage one of the Resident Quality Inspection, an identified resident was noted as having respiratory infection from the Minimum Data Set (MDS) Assessment.

A Quarterly MDS Assessment was completed for the resident on a specific date due to a significant change. The MDS Assessment indicated that the resident had a respiratory infection.

In an interview, a Registered Nurse (RN) stated that the resident would be monitored for symptoms of infection on each shift and that this was documented under the Infection Follow up Note in the resident's progress notes. The RN indicated that each resident with signs and symptoms of infection was put on a Daily Infection Control Surveillance Form.

A review of the Daily Infection Control Surveillance Form for a specific home area noted that the resident had an onset of respiratory symptoms with a recorded onset date. The date resolved on the form was blank.

Record review of the resident's progress notes on PCC for the specific date range showed that 17 out of 30 (56.6 per cent) shifts did not have documentation of the symptoms of infection for the resident.

In an interview on a specific date, the Assistant Director of Resident Care (ARDC) reviewed the resident's progress notes with the inspector. The ARDC stated that all registered staff should have completed an Infection Follow up note for the resident until the resident finished their medications and they were symptom free and should have noted the date the resident's symptoms had resolved.

c) During stage one of the Resident Quality Inspection, an identified resident was noted as having a respiratory infection from the Minimum Data Set (MDS) Assessment.

Review of the MDS quarterly review assessment for a specific date, indicated that the resident had a respiratory infection.

Review of the "Respiratory Line Listing" for outbreak for a specific date, showed symptoms of infection for the resident, with an identified recorded onset date and an outcome completion date.

The Home's policy titled "Surveillance and Process of Data Collection" reference number 004020.00, stated the following: "Relevant infection prevention and control information will be documented in the resident's progress notes in PCC (e.g. date of isolation) by the frontline care provider(s) and/or the Infection Control Practitioner".

Record review of the progress notes on Point Click Care (PCC) for the specific date range showed that 17 out of 24 (71 per cent) shifts did not have documentation of the symptoms of infection for the resident.

In an interview with a Registered Practical Nurse (RPN) with inspectors on a specific date, the RPN said that the Home's expectation was to document the residents' symptoms of infection in PCC progress notes, at a minimum, every shift.

In an interview with the Assistant Director of Resident Care (ADRC) with inspectors on a specific date, the ADRC said that nursing staff were to complete a progress note with daily monitoring of the infection in PCC, and the expectation was that documentation was to be completed every shift. The inspector showed the ADRC dates of documentation from the progress notes and they acknowledged that the documentation was missing and should have been completed every shift.

The licensee has failed to ensure that the symptoms of infection for residents were documented on every shift. [s. 229. (5) (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 on every shift the symptoms of infection for residents are recorded, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Long-Term Care Homes Act 2007, c. 8, s. 20 (2) states, "At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall provide for a program, that complies with the regulations, for preventing abuse and neglect."

Ontario Regulation 79/10, s. 215 (2) states,"The criminal reference check must be, conducted by a police force; and conducted within six months before the staff member is hired or the volunteer is accepted by the licensee."

Ontario Regulation 79/10, s. 215 (3) states, "The criminal reference check must include a vulnerable sector screen to determine the person's suitability to be a staff member or

volunteer in a long-term care home and to protect residents from abuse and neglect."

A review of pre-screening of four random employees and a volunteer hired within the past four months noted the following:
- Pastoral Care staff with an identified hire date did not have a police check on file. A receipt from London Police with a specific date, indicated that a police check had been paid for and was on file.

In an interview, the Executive Director of Resident Care stated that a Pastoral Care staff was currently working.

A review of the home's policy Vulnerability Screening Reference Number 002090.00, stated, "The candidate will receive the report and bring the original to their direct supervisor for review and filing. If the candidate is required to work prior to receiving the report, he/she must present the receipt from the police department as proof of application."

In an interview on a specific date, the Administrator confirmed that accepting a receipt of a criminal reference check did not meet the regulations that a criminal reference check must be obtained before hire.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with all applicable requirements under the Act. [s. 20. (2)]

Issued on this 11th day of July, 2018

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

Original report signed by the inspector.