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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2019	2018_605213_0028	003949-17, 027248-17, 027835-17, 002624-18, 006353-18, 009462-18, 027631-18, 027728-18, 030872-18, 031867-18	Critical Incident System

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

RHONDA KUKOLY (213), CHRISTINA LEGOUFFE (730), DONNA TIERNEY (569), KRISTEN MURRAY (731)

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): December 10, 11, 12, 14, 17, 18, 19, 20, 2018.

This inspection was completed related to the following critical incidents:
Log #003949-17 Critical Incident #2980-000004-17 related to alleged staff to resident verbal abuse/neglect.
Log #027248-17 Critical Incident #2980-000031-17 related to alleged resident to resident sexual abuse.
Log #027835-17 Critical Incident #2980-000033-17 related to alleged staff to resident neglect.
Log #002624-18 Critical Incident #2980-000003-18 related to transferring and positioning.
Log #006353-18 Critical Incident #2980-000009-18 related to a fall.
Log #009462-18 Critical Incident #2980-000020-18 and #2980-000021-18 related to altercations between residents.
Log #027631-18 Critical Incident #2980-000051-18 related to a fall.
Log #030872-18 Critical Incident #2980-000055-18 related to alleged resident to resident physical abuse.

The following critical incidents were also reviewed while in the home:
Log #027728-18 Critical Incident #2980-000052-18 related to a fall.
Log #031867-18 Critical Incident #2980-000057-18 related to a fall.
Log #020324-18 Critical Incident #2980-000037-18 related to alleged staff to resident neglect.
Log #003525-18 Critical Incident #2980-000006-18 related to alleged staff to resident abuse.
Log #025180-18 Critical Incident #2980-000046-18 related to a missing resident.
Log #025734-18 Critical Incident #2980-000048-18 related to alleged resident to resident sexual abuse.
Log #017321-18 Critical Incident #2980-000029-18 related to alleged resident to resident physical abuse.
Log #007103-18 Critical Incident #2980-000012-18 related to alleged staff to resident abuse.
Log #017918-18 Critical Incident #2980-000030-18 related to alleged resident to resident sexual abuse.
Log #014140-18 Critical Incident #2980-000026-18 related to alleged resident to resident physical abuse.
Log #025770-17 Critical Incident #2980-000027-17 related to alleged staff to resident emotional abuse.
Log #023002-18 Critical Incident #2980-000040-18 related to a missing resident.

Log #007089-18 Critical Incident #2980-000011-18 related to alleged staff to resident verbal abuse.
Log #028679-17 Critical Incident #2980-000035-17 related to alleged resident to resident sexual abuse.
Log #025598-17 Critical Incident #2980-000028-17 related to alleged staff to resident emotional abuse.
Log #004993-18 Critical Incident #2980-000008-18 related to alleged staff to resident verbal abuse and care concerns.
Log #015828-18 Critical Incident #2980-000027-18 related to alleged resident to resident physical abuse.
Log #024978-18 Critical Incident #2980-000045-18 related to alleged resident to resident physical abuse.
Log #007371-18 Critical Incident #2980-000015-18 related to responsive behaviours.
Log #025373-18 Critical Incident #2980-000047-18 related to alleged staff to resident abuse/neglect.
Log #005733-18 Critical Incident #2980-000007-18 related to alleged staff to resident verbal abuse.
Log #024515-18 Critical Incident #2980-000043-18 related to alleged staff to resident abuse/neglect.
Log #019249-18 Critical Incident #2980-000035-18 related to alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Administrator, the Director of Care, the Assistant Director of Care, a Physician, a Pharmacist and Pharmacy Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also made observations and reviewed health records, policies and procedures, internal investigation records, employee files, education records, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 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	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. 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 devices or techniques when assisting residents.

A Critical Incident Report (CIS) submitted to the Ministry of Health and Long-Term Care identified that a resident sustained an injury while staff were transferring the resident.

A clinical record review, review of the home's investigative notes and the CIS, indicated that staff reported that while transferring a resident into a wheelchair, the resident began to call out in discomfort and a staff member realized there had been a problem with the transfer and the resident had suffered an injury.

In an interview with a staff member, they stated that when transferring the resident, there had been a problem with the transfer and the resident had suffered an injury. The staff member called a registered nursing staff to assess the resident.

A clinical record review and an interview with the Assistant Director of Care (ADOC) indicated that assessments conducted by registered staff identified swelling and pain in an identified area and then there was bruising. The physician, the POA and other health professionals were notified. Further assessments by health professionals and diagnostic tests showed an injury.

The ADOC stated that although the staff did not intentionally injure the resident, the staff did not use safe transferring and positioning techniques.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting resident that resulted in an injury. [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 devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference number 005010.00 indicated that any staff, who has reasonable grounds to suspect abuse or suspected abuse stated in part "An employee shall report to their immediate supervisor and if not able to do so to the Manager On-Call. The Manager is responsible for immediately reporting this suspicion to the Director (MOHLTC) via After Hours reporting or completing Mandatory Incident report form online and submitting to Central Intake and Triage Team (CIATT)."

A) On an identified date, the home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding alleged resident to resident physical abuse resulting in a minor injury.

A review of a resident's progress notes in Point Click Care stated that the above incident had occurred and there was no documented evidence that the registered staff reported the abuse to the home's management that day.

During interviews, the Assistant Director of Care (ADOC) stated that the home's expectation was that staff would immediately report any allegations of abuse or neglect to management and they would report immediately to the Director. The ADOC stated that staff did not report the allegations of abuse to management. (730)

B) On an identified date, the home submitted a CIS report to the MOHLTC regarding alleged resident to resident sexual abuse.

The critical incident documented that the incident occurred on an identified date and time and was submitted to the MOHLTC two days later. The CIS also indicated that the MOHLTC after hours pager was not contacted about the incident.

An onsite inquiry interview was conducted with Assistant Director of Care (ADOC). They agreed that the Critical Incident related to abuse of a resident by anyone was submitted to the Director two days after the incident occurred. The ADOC said they could not confirm whether the staff who identified the alleged sexual abuse incident did not report it to their supervisor immediately, or if the manager who submitted the CIS to the MOHLTC did so two days after learning of the incident. The ADOC did acknowledge that the home did not comply with their policy to promote zero tolerance by not reporting the alleged sexual abuse incident to the Director immediately as per the legislative requirements. (569)

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20.]

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.