Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**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 |
|---|---|---|---|
| Nov 5, 2019 | 2019_819524_0009 | 020580-19, 020785-19 | Complaint |

## 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), CHRISTINA LEGOUFFE (730)

## 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): October 30 and 31, 2019.**

**The following Complaint intakes were completed within this inspection:**
**Log #020580-19 / IL-71435-LO related to sufficient staffing;**
**Log #020785-19 / IL-71547-LO related to falls management and medication administration.**

**During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, an Assistant Director of Care, two Registered Nurses, five Registered Practical Nurses, two Personal Support Workers, a family member and residents.**

**The inspector(s) also observed resident rooms, observed residents and the care provided to them, observed a medication pass, reviewed health care records and plans of care for identified residents and reviewed relevant policies and procedures of the home.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Medication**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MOLTC) Action Line received a complaint which included concerns related to the care of resident #001. The complainant stated that on a specific date, resident #001 left an identified area of the home, unassisted, and sustained an unwitnessed fall at the home. The complainant stated that as a result of the fall, the resident sustained an injury and was disoriented.

A review of the progress notes in Point Click Care (PCC) for resident #001, on specific date and time, stated that the resident had an unwitnessed fall and sustained injuries to several areas of their body. The resident required an external medical assessment.

Review of the assessments section in PCC showed an assessment titled "Fall Risk Screening and Post Fall Assessment – V 4," on a specific date.

Resident #001's plan of care in PCC was reviewed and showed resident #001 was at risk for falls and interventions identified specific falls prevention strategies.

During an interview Personal Support Worker (PSW) #104 said they were working when resident #001 fell. They said that they had left a specific area of the home to answer a call bell and while they were gone one of their colleagues had heard someone yelling. They said that resident #001 was on the floor. The PSW said that normally they would walk with the resident from the specific area of the home back to their room, but on this occasion the resident got up alone, with their walker.

During an interview with Assistant Director of Care (ADOC) #102, they said that they were the Falls Lead in the home, and that they were familiar with resident #001 and their fall on a specific date. They said they had completed the investigation related to the fall. When asked if they were able to review the video footage from the cameras in the identified area of the home, where resident #001 was sitting prior to the fall, the ADOC said that those cameras were not functioning. They said that they would have expected a staff member to walk with the resident from the identified area of the home to their room.

The licensee has failed to ensure that the care set out in the plan of care, related to falls prevention, was provided to resident #001 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the licensee was required to ensure that the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's "Fall Prevention & Management-Falls Risk Factors & Related Interventions" strategy (#005190.00), which was part of the licensee's Falls Prevention and Management program, which required registered staff to complete a Head Injury Routine (HIR) for 72 hours after an unwitnessed fall.

The home's policy titled "Head Injury Routine" (HIR) stated "Resident on Head injury routine check must be woken if not awake; if resident refuses please document the

refusal. For resident's [sic] who is awake and cognitively impaired who refuses, please re-approach. If resident still refuse, document the refusal. If a fall requiring a HIR and another HIR is in progress Registered Staff is to start a new HIR."

A) The Ministry of Long-Term Care (MOLTC) Action Line received a complaint which included concerns related to the care of resident #001. The complainant stated that on a specific date, resident #001 left an identified area of the home, unassisted, and sustained an unwitnessed fall at the home. The complainant stated that as a result of the fall, the resident sustained an injury and was disoriented.

A review of the progress notes in Point Click Care (PCC) for resident #001, on a specific date and time, stated that the resident had an unwitnessed fall and sustained injuries to several areas of their body. The resident required an external medical assessment.

The clinical records for resident #001 were reviewed and showed an assessment titled "Fall Risk Screening and Post Fall Assessment – V 4," on a specific date. The assessment documented the fall as unwitnessed, that the resident hit their head during the fall, and that a HIR "must be completed for full cycle (72 hours)".

During an interview, Registered Practical Nurse (RPN) #107 said that the expectation of the home was that a HIR record was completed when a resident had an unwitnessed fall or known head trauma and that it was documented on paper.

The "Head Injury Routine" record for resident #001, on an identified date with a specific initial start time was reviewed and showed that numerous checks were not documented. The resident was documented to be 'sleeping' for one of the multiple checks and there was no documentation which indicated that the resident was woken.

During an interview, RPN #105 reviewed the HIR record for resident #001 and said that it did not appear to have been completed.

During an interview, Assistant Director of Care (ADOC) #102 said that they were the Falls Lead in the home and were familiar with resident #001 and their fall on a specific date. ADOC reviewed resident #001's HIR form and said that it did not meet the home's expectation in terms of completeness.

B) Resident #005 was identified by ADOC #102 during an interview on a specific date, as a resident who had recently sustained an unwitnessed fall.

Review of the progress notes in PCC for resident #005, showed a note titled "Incident Note," on a specific date, which stated that the resident was observed sitting on the floor beside the bed. The note stated that a Post Fall assessment was completed and the HIR protocol was initiated.

The clinical records for resident #005 were reviewed and showed an assessment titled "Fall Risk Screening and Post Fall Assessment – V 4," on a specific date. The assessment documented the fall as unwitnessed and that a HIR "must be completed for full cycle (72 hours)".

During an interview, Registered Nurse (RN) #109 said that they were familiar with resident #005 and that they were at risk for falls. They said that resident #005 had sustained a fall on a specific date and that there should have been a completed HIR record in the resident's paper chart.

The "Head Injury Routine" record for resident #005 was reviewed and showed that numerous checks were not documented. There was no documentation in resident #005's progress notes which indicated that the resident was sleeping or had been woken for checks.

During an interview, ADOC #102 said after review of the HIR for resident #005, that there were some blanks on their HIR form and that they would have to check the progress notes in PCC, as the registered staff may have documented there if the resident was sleeping. When asked if they would expect registered staff to wake a sleeping resident up to complete a HIR check, they said no.

During an interview, Registered Nurse (RN) #110 said that the home's policy stated that registered staff should wake a sleeping resident to complete a HIR check, but that they personally did not always wake them. RN #110 said that the home had changed their policy and procedures related to HIRs in the last few months. The RN said that the new policy was very hard for staff to follow as it was a much more in-depth tool and was often not being fully completed by staff. RN #110 reviewed the HIR for resident #005 and said that it was not completed as per the home's policy.

The licensee has failed to ensure that the home's strategy for Falls Prevention and Management was complied with, related to the completion of Head Injury Routines, when residents #001 and #005 had unwitnessed falls. [s. 8. (1) (a),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 to ensure that where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A complaint was reported to the Ministry of Health and Long-Term Care Infoline on a specific date, regarding the medication management for resident #001 in the home. The complainant stated that on an identified date, when they arrived at the home for a visit at a specific time, medication was found at resident #001's bedside table. The nurse had given the medication but had not ensured that the medication had been taken by the resident.

Review of resident #001's clinical record showed the following:
-the progress notes created by a registered staff on a specific date, documented a medication incident that the POA found medications on the bedside table. The registered staff noted there were multiple medications in a cup. When they checked with resident #001 they stated it was from an earlier medication pass.
-an identified medication incident report noted that on a specific date, resident #001 was not administered their specific dose of medication as ordered and was found in the

resident's room still in the medication cup.
-the care plan directed staff to provide "medication as per physicians orders".
-the physician orders in PointClickCare showed specific medications were to be given at specific times.
-the Medication Administration Record indicated that the medications were signed as administered on a specific date and time by Registered Practical Nurse #106.

In an interview, Registered Practical Nurse (RPN) #106 said that they had poured the medication in a cup and gave it to resident #001. RPN #106 acknowledged that they had not stayed in the room to watch the resident take their medication.

During an interview, ADOC #102 acknowledged that the medications were not administered to resident #001 in accordance with the directions for use specified by the prescriber.

B) A review of a medication incident report noted that on a specific date, resident #002 was not administered their specific dose of multiple medications as ordered. The medication incident report indicated these medications were left in a bin and had not been given. A review of resident #002's Medication Administration Record (MAR) for the identified date, showed that the medications were signed as administered by the registered nurse (RN). There were no adverse effects to the resident.

C) A review of a medication incident report noted that on a specific date, resident #003 was not administered their specific dose of multiple medications as ordered. The medication incident report indicated that the medications were found left in a bin. A review of resident #003's MAR for the identified date, showed that the medications were signed as administered by the RN. There were no adverse effects to the resident.

During an interview, Assistant Director of Care #102 reviewed the medication incidents and acknowledged that the medications were not administered to resident #002 and #003 in accordance with the directions for use specified by the prescriber. ADOC #102 stated that it was an expectation that the physicians' orders were followed as directed.

The licensee has failed to ensure that drugs were administered to resident #001, #002, and #003 in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**Issued on this 5th day of November, 2019**

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

**Original report signed by the inspector.**