Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 28, 2020	2020_729615_0002	020649-19, 021804-19, 001284-20	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

HELENE DESABRAIS (615), ALI NASSER (523)

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): January 14, 15 and 22, 2020.

The following Critical Incident (CI) reports were inspected during this inspection:
CI #2980-000037-19/Log #020649-19 related to prevention of abuse and neglect,
CI #2980-000038-19/Log #021804-19 related to falls prevention,
CI #2980-000002-20/Log #000402-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (Acting DOC), two Assistants Director of Care (ADOCs), the Director of Accomodations, the Director of Programs (DP), one Registered Nurse (RN), one Registered Practical Nurse (RPN), one Cook, one Personal Support Worker-Behavioural Support Ontario (PSW-BSO), eight Personal Support Workers (PSWs) and residents.

During the course of this inspection the Inspector(s) observed the overall maintenance and cleanliness of the home and equipment, observed staff to resident interactions, observed the provision of care, reviewed relevant internal documentation, reviewed relevant clinical records and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included an analysis and follow-up actions of the long-term actions planned to correct the situation and prevent recurrence.

On a specific date, Critical Incident (CI) 2980-000037-19/Log #020649-19 was submitted to the Ministry of Long term Care related to prevention of abuse.

Review of the CI revealed that on a specific date, one resident was found allegedly abusing another resident. The CI report was not amended to include an analysis and follow-up actions of the long-term actions planned to correct the situation and prevent recurrence.

Review of the home's policy #003400.00 "Mandatory/Critical Incidents" last updated September 7, 2018, stated in part under Investigation, Response and Action "The licensee must report to the Director the results of the investigation and the action taken. If the licensee cannot provide all information by 10 days then a preliminary report must be submitted within 10 days and a final report within time frame specified by the Director."

During an interview, Administrator #100 stated that the Director of Care was the staff member who would amend a CI report and added that this CI was not amended and would of expect the CI be completed within 10 days including an analysis and follow-up actions of the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that the report to the Director included an analysis and follow-up actions of the long-term actions planned to correct the situation and prevent recurrence. [s. 104. (1) 4.]

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.