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
Nov 3, 2020	2020_725522_0009	019716-20	Critical Incident System

Licensee/Titulaire de permis

peopleCare Communities 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

JULIE LAMPMAN (522)

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): October 26 and 27, 2020.

The following intake was inspected:
Critical Incident System (CIS) report #2980-000017-20/Log #019716-20 related to falls prevention.

This inspection was completed concurrently with Complaint Inspection #2020_725522_0010/Log #020099-20 related to improper care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a Registered Nurse, Registered Practical Nurse, Personal Support Worker and a resident.

The inspector also observed resident care, staff to resident interactions, reviewed resident clinical records, critical incident system reports and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the home was unable to determine within one business day if resident #001's fall and hospitalization resulted in a significant change in status, that the Director was informed no later than three business days after the occurrence of the incident.

A review of a Critical Incident System (CIS) report noted resident #001 had a fall. The CIS report was submitted seven days after the fall and noted the resident had suffered a significant injury.

A review of resident #001's electronic progress notes in Point Click Care noted documentation two days after the fall, that resident #001 had possibly suffered a significant injury.

A review of resident #001's progress notes four days after resident #001 fell, noted the resident had suffered a significant injury which required changes to their plan of care.

In an interview, Director of Care (DOC) #101 verified the CIS report had been submitted late and should have been submitted when the home determined resident #001 had a significant change in status.

Sources
CIS Report, progress notes, interviews with resident #001, Registered Practical Nurse #103 and DOC #101. [s. 107. (3.1) (b)]

Issued on this 17th day of November, 2020

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

Original report signed by the inspector.