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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2014	2013_254515_0010	L-001035-13	Critical Incident System

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0

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

RAE MARTIN (515)

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 27, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, the Office Manager, the Receptionist, 1 Registered Staff and 8 Personal Support Workers.

During the course of the inspection, the inspector(s) toured 2 resident home areas and reviewed resident health records and staff memos.

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

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident's environment was kept safe. 2007, c. 8, s. 3 (1)(5).
A resident sustained an unwitnessed fall resulting in injury and subsequent death. The resident was found on the floor in a bedroom between the bed and reclining chair with the resident's wheelchair close by. The resident did not have the wheelchair alarm in place. Further investigation by the home revealed the sensor pad was not working.
The resident was not kept safe as evidenced by:
A) The resident's health record fall note documentation states the resident was last seen seated in the wheelchair prior to the fall.
B) The resident's care plan intervention states that a sensor pad must be in use while the resident is in the wheelchair.
C) There is no documentation in the resident's health record stating the chair alarm was in place that day.
D) The Director of Care and the Assistant Director of Care confirmed the chair alarm was not in place when the resident was in the wheelchair and that the resident's safety needs are to have the chair alarm in place. [s. 3. (1) 5.]

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 the residents' environment is kept safe, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted as evidenced by:
A) There is no post fall assessment documented for one of the resident's falls.
B) The Assistant Director of Care confirmed that a post fall assessment was not done for one of the resident's falls. [s. 49. (2)]

Issued on this 2nd day of January, 2014

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

RAE NYLANDER-MARTIN