Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: January 17, 2023
Inspection Number: 2023-1489-0002
Inspection Type: Critical Incident System
Licensee: peopleCare Not-For-Profit Homes Inc.
Long Term Care Home and City: peopleCare A.R. Goudie Kitchener, Kitchener

Lead Inspector	**Inspector Digital Signature**
Robert Spizzirri (705751)	Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2023.01.17 15:01:33 -05'00'

Additional Inspector(s)
Yami Salam (000688)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 5-6, and 9-12, 2023

The following intake(s) were inspected:

- Intake: #00007723 and #00016849 related to abuse and neglect.
- Intake: #00008317 related to fall prevention and management.
- Intake: #00015239 related to an unexpected death.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Food, Nutrition and Hydration
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021 s. 28 (1) 2

The licensee has failed to ensure when a person has reasonable grounds to suspect abuse of a resident by anyone, or neglect of a resident by staff that resulted in harm or a risk of harm to the resident has occurred, they shall immediately report the suspicion and the information upon which it is based to the Director.

Vicariously liable, section 154 (3) of the FLTCA, 2021 states (3) Where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

The Director was notified that a staff member reported, late, two incidents of suspected abuse and/or neglect.

a) Approximately one to two months prior to reporting the incident to the home, a staff member was observed to have declined a residents' request, and made an insulting remark which resulted in the resident crying.

b) Approximately 11 days prior to reporting the incident to the home, a staff member was observed to ignore a resident. The resident became emotionally and physically responsive.

The DOC said that both incidents were alleged abuse and should have been reported immediately.

When staff failed to report incidents of abuse immediately, the home and Director were unable to take immediate action, as required.

Sources: Critical Incident, Home's Internal Investigation, Interview with DOC, and other staff.

[705751]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that residents are protected from abuse by anyone and ensure that residents are not neglected by the licensee or staff.

Emotional abuse as per O. Reg. 246/22 s. 2 (1) (a), is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A staff member was observed to have declined a residents' request and made an insulting remark which resulted in the resident crying.

The home investigated and concluded the staff members actions were emotional abuse.

The DOC said that this incident had emotional impact to the resident at the time of the incident.

When staff use inappropriate language, it increases the risk of emotional harm to the resident.

Sources: Critical Incident, Home's Internal Investigation, Interview with DOC, and other staff.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 25 (1)

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

Rationale and Summary

The homes Abuse or Suspected Abuse/Neglect of a Resident Policy states that any employee upon becoming aware of potential or actual abuse will safeguard the resident immediately, and that the staff member will be sent home pending investigation.

A resident alleged a staff member had emotionally and physically harmed them during care. The resident was not able to identify the staff member by name.

A staff member did not investigate and assumed who the alleged aggressor was. The wrong staff member was sent home, and the alleged aggressor remained in the home.

The DOC said staff should have investigated by asking staff who provided care, reviewing documentation and/or the scheduled assignments.

When staff failed to investigate properly, they failed to safeguard the resident, remove the alleged aggressor from the home, and may have increased the risk of further instances of abuse.

Sources: Home's internal investigation notes, abuse or suspected abuse/neglect of a resident policy (005010.00), interview with DOC and other staff.

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