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_0010	020099-20	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): October 27, 28, 29, 30, 2020.

The following intake was inspected:
Complaint Log #020099-20 related to improper care.

This inspection was completed concurrently with Critical Incident System inspection #2980-000017-20/Log #019716-20 related to falls prevention.

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

The inspector also reviewed resident clinical records, hospital records, the home's complaints binder and investigative notes, critical incident system reports and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of a resident, abuse of a resident by anyone and neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Review of the home's "Concerns Complaints 2020 Investigations" binder noted the following:

Resident #001's Power of Attorney (POA) made a complaint to the Executive Director (ED) related to improper care of resident #001.

Resident #002's POA had made a complaint that resident #002 had been neglected.

Resident #003 had made a complaint of verbal abuse from a staff member.

Review of the Ministry of Long-Term Care – Long-Term Care Homes Portal noted the home had not reported the complaints related to improper care of resident #001, neglect of resident #002 and verbal abuse of resident #003 to the Director.

In an interview, ED #100 verified they had received complaints regarding resident #001, resident #002 and resident #003. ED #100 investigated the complaints and acknowledged they had not reported the allegations of improper care, neglect and abuse immediately to the Director.

Sources
The home's "Concerns Complaints 2020 Investigations" binder; the LTCH's investigative notes; the Ministry of Long-Term Care – Long-Term Care Homes Portal and interviews with resident #001's POA and Executive Director #100. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that improper care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm has occurred, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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.