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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 9, 2024
Inspection Number: 2024-1462-0003
Inspection Type: Complaint Critical Incident
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Oakcrossing London, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 12, 15, 16, 17, 18, 19, 22, 23, 2024.

The following intake(s) were inspected:

- Intake: #00118592 - Complaint related to allegations of resident abuse;
- Intake: #00119242 - Critical incident system (CIS) #2980-000032-24, related to the falls prevention and management program;
- Intake: #00119390 - Complaint related to allegations of improper/incompetent treatment of a resident;

The following intake was completed as part of this inspection:

- Intake: #00119421 - CIS #2980-000035-24, related to the falls prevention and management program.

Program Specialist was onsite July 12, 15, 16 and 17, 2024.

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

- Skin and Wound Prevention and Management
- Medication Management
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Pain Management
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:

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An observation showed the resident had devices engaged that were not supposed to be engaged as per the resident's plan of care.

A Personal Support Worker (PSW) confirmed there were certain circumstances during which the devices should be engaged. However, under the current circumstances observed the devices should not have been engaged, and the PSW remedied the situation. The licensee's failure to provide the plan of care as specified in the plan did not impact the resident and resulted in a low risk of harm.

Sources: Observations, interviews with staff and clinical record reviews.

Date Remedy Implemented: July 12, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure there was a written plan of care for more than one resident, that set out clear directions to staff providing direct care to these residents.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to alleged staff to resident abuse, involving a resident.

During the course of the inspection a lack of clear direction related to the monitoring of a resident's altered skin integrity was identified.

A review of the resident's clinical records documented the resident was receiving a regular dose of a medication for which staff were required to monitor certain side effects. On two occasions, more than one area of altered skin integrity was identified by staff; however, there was no additional documentation to support the staff had completed ongoing monitoring of the resident. The Director of Care (DOC) said they would expect staff to complete ongoing monitoring of the resident until the area of altered skin integrity had resolved.

When there was a lack of clear direction for staff related to the monitoring of the resident, it impacted the resident's right to receive ongoing monitoring, and increased their risk of unidentified medical complications.

Sources: Resident clinical records, and interviews with management.

Rationale and Summary:
A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC), regarding the fall of a resident.

A record review and interviews supported there was a lack of clear direction for front line staff when they were unable to identify when or if mode of locomotion had changed for this resident, or could indicate the type of assistance or equipment required for this resident to ambulate safely throughout the home.

Failing to provide clear directions to staff and others who provide direct care to this resident regarding safe locomotion had the potential to increase the risk of falls and

potential injury.

Sources: Interviews with staff, clinical record reviews and observations.

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)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure their policy to promote zero tolerance of abuse of residents was complied with, related to allegations of staff to resident abuse when not all investigative steps were completed as per the home's policy

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to allegations of staff to resident abuse involving a resident.

A review of the home's investigation notes, documented two written records maintained by the home.

A review of the home's Abuse or Suspected Abuse/Neglect of a Resident policy and interview with the Vice President of Long-Term Care Homes Operations supported there were specific responsibilities for all staff members to fulfill once they had become aware of suspected abuse of this resident, and those

responsibilities were not fulfilled. When the licensee failed to comply with their own policy and complete a fulsome investigation this impacted the resident's right to due process and increased their risk of harm.

Sources: Abuse or Suspected Abuse/Neglect of a resident policy, the home's investigation notes and interviews with management.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure that when they received a written complaint concerning the care of a resident that alleged harm or risk of harm to that resident, the complaint was immediately forwarded to the Director in the format provided for in the regulations and that complied with any other requirements provided for in the regulations.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to an allegation of incompetent/improper treatment of a resident by staff.

A review of the written complaints sent to the Director of Care (DOC), documented

several allegations concerning the care of a resident and the operation of the home.

The DOC confirmed the written complaints documented allegations of harm or risk of harm to a resident, and that a Critical Incident System (CIS) report should have been immediately forwarded to the Director as legislated.
When these allegations were not forwarded immediately to the Director, the licensee impacted the resident's rights to ensure they were receiving the care they required and increased their risk of harm.

Sources: Written complaints and interviews with management.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

The licensee failed to ensure that every alleged or suspected incident of neglect of a resident that resulted in harm or a risk of harm to a resident was immediately investigated.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint alleging neglect of a resident.

A review of the written complaints sent to the Director of Care (DOC), documented several allegations concerning the care of a resident and the operation of the home.

The DOC confirmed the written complaints documented allegations of harm or risk of harm that could have amounted to neglect of the resident, for which the licensee was obligated to complete an immediate investigation as per the legislation.
When the home failed to immediately investigate, the licensee impacted the resident's right to reside in a safe and secure home and increased the resident's risk of harm.

Sources: Resident records, the home's investigation records and interviews with management.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

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

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received a complaint related to allegations of staff to resident abuse, involving a resident.

A review of the MLTC reporting system and Long-Term Care Homes.net supported there were no records of a Critical Incident System (CIS) report having been submitted by the home. The Director of Care and the Vice President of Long-Term Care Operations, said a CIS report related to allegations of staff to resident abuse, involving the resident was not submitted to the Director and should have been. When the licensee failed to submit a CIS report to the Director this impacted the resident's right to have their concerns investigated and increased the resident's risk of harm.

Sources: MLTC reporting system, Long-Term Care homes.net and interviews with management.

WRITTEN NOTIFICATION: Falls Prevention and Management policy

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was complied with, specifically where staff were required to complete documentation for head injury routine (HIR) monitoring for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, strategies to reduce the risk of injury and that it must be complied with.

Specifically, staff did not comply with the requirements outlined for the homes HIR documentation.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to a resident's fall.

Review of the home's Falls Prevention Management Program stated "Post Falls Assessment: The Registered Staff will:
"7.Initiate Head Injury Routine for any resident who receives a blow to the head either from a fall (including all unwitnessed fall) or personal injury using Head Injury Routine Form. and
8.Monitor HIR for 72 hours post fall for signs of neurological changes, i.e., change in LOC, Severe headache not relieved by pain medication, abnormal drowsiness, increased restlessness, and personality changes."

Review of the resident's clinical records indicated they sustained an unwitnessed fall for which the completion of HIR form was required. A review of the resident's HIR identified the form was not filled out in full as per the home's policy.

A Registered Practical Nurse (RPN) stated that it was the expectation of the home that residents were woken up, if sleeping, to complete the HIR form. The home's failure to fully complete the resident's neurological assessments post-fall, impacted the resident's right to receive appropriate assessments and had the potential to increase the resident's risk of an unidentified injury, requiring medical attention.

Sources: Review of the home's Falls Prevention Management Program Policy, clinical record reviews, and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, received a complete skin assessment.

Rationale and Summary:
A complaint was received by the Director concerning the care of a resident's altered skin integrity. A clinical record review noted there were multiple areas of altered skin integrity identified by the registered nursing staff. However, there were no specific assessments as per the legislation.

An interview with a Registered Nurse (RN) supported that the expectation was that altered skin integrity specific assessments should have been completed for each identified area of altered skin integrity. When the resident was exhibiting altered skin integrity, and a clinically appropriate assessment instrument specifically designed

for skin and wound assessment was not completed, the resident was placed at risk for receiving wound care interventions that may not have been based on a complete assessment.

Sources: interviews with staff and clinical record reviews.

WRITTEN NOTIFICATION: Skin and Wound

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that when a resident was exhibiting altered skin integrity, the resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, specific to the identified area.

Rationale and Summary:
A complaint was received by the Director, concerning the care of a resident's altered skin integrity. During a record review, it was noted that the resident had several identified areas of altered skin integrity. However, documentation did not reflect that one of the identified areas was assessed to determine what care and interventions should have been provided as per best practice guidelines. An Assistant Director of Care (ADOC) and a Registered Nurse (RN) acknowledged that nurses were to provide wound care as per best practice guidelines. The RN verified, that although an area of altered skin integrity was identified the resident did not

receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection related to that area.
When the resident exhibited altered skin integrity and did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection the resident was placed at risk for delayed care, with a potential impact on the resident's quality of life.

Sources: Interviews with staff, and clinical record reviews.

WRITTEN NOTIFICATION: Skin and Wound

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Rationale and Summary:
A complaint was received by the Director concerning the care of a resident's areas of altered skin integrity. During a record review it was noted that when the multiple areas of altered skin integrity were identified there was inconsistent completion of the required weekly wound assessment as legislated.

During an interview with a Registered Nurse (RN) they confirmed that weekly assessments were not completed and should have been. By not ensuring that weekly assessments were completed using a clinically appropriate assessment instrument, the resident was at risk for delayed wound care with a potential of impacting the resident's quality of life.

Sources: Staff interviews, and clinical record reviews.

WRITTEN NOTIFICATION: Dealing with complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that every written complaint made to the licensee concerning the care of a resident or operation of the home was dealt with, including a response to the person who made the complaint with the following:

- the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
- an explanation of what the licensee has done to resolve the complaint, and
- confirmation that the licensee immediately forwarded the complaint to the Director.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to an allegation of incompetent/improper care of a resident by staff.

A review of the written complaints sent to the Director of Care (DOC) documented several allegations concerning the care of a resident, and the operation of the home.

A review of the home's dealing with complaints records supported there were no written records kept by the home related to care concerns involving this resident.

The DOC confirmed their response to the complainant did not include the MLTC and Patient Ombudsman's contact information, an explanation of what the licensee had done to resolve the complaint and their response failed to confirm that the complainant's concerns were immediately forwarded to the Director. When the licensee failed to deal with the complainant's concerns regarding this resident's care, the licensee impacted the resident's right to have the home ensure they were receiving care consistent with their needs and increased the resident's risk of ongoing incompetent/improper care.

Sources: Resident clinical records, the home's dealing with complaints records and interviews with management.

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record was kept in the home that included the following:
- the nature of the written complaint;
- the date the complaint was received;
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to an allegation of incompetent/improper care of a resident by staff.

A review of the written complaints sent to Director of Care (DOC) documented several allegations concerning the care of a resident, and the operation of the home.

A review of the home's dealing with complaints records supported there were no written records kept by the home related to care concerns involving this resident.

The DOC confirmed they did not keep a documented record in the home detailing the complainant's care concerns for this resident as legislated. When the licensee failed to document a record of the complainant's concerns for the resident's care, the licensee impacted the resident's right to have the licensee ensure they were receiving care consistent with their needs and increased the resident's risk of ongoing incompetent/improper care.

Sources: Resident clinical records, the home's dealing with complaints records and interviews with management.