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

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Public Report

Report Issue Date: December 24, 2024

Inspection Number: 2024-1462-0005

Inspection Type:
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): December 12, 13, 16, 18, 19, 20, 23, 2024

The following intake(s) were inspected:

- Intake: #00126733 - (2980-000053-24) CIS related to the fall of a resident
- Intake: #00128711 - (2980-000057-24) CIS related to suspected abuse and neglect of a resident
- Intake: #00131201 - (2980-000061-24) CIS related to an outbreak
- Intake: #00131447 - (2980-000063-24) CIS related to an unexpected death of a resident

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1)

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,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve;

(c) clear directions to staff and others who provide direct care to the resident; and

(d) any other requirements provided for in the regulations.

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned personal care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident. The Assistant Director of Care verified the written plan of care for the resident did not set out the planned personal care for oral hygiene.

Sources: clinical record review for the resident, and staff and ADOC interview.

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 that the fall prevention written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident. There were multiple interventions that were either discontinued or not added to the plan of care.

Sources: Sources: clinical record review for the resident, observations, and staff interviews.

WRITTEN NOTIFICATION: Based on Assessment of Resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the fall prevention care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident. The resident was assessed by a Physiotherapist (PT) for fall prevention strategies. The plan of care did not identify the strategies and the Assistant Director of Care verified the plan of care was not based on the PT assessment.

Sources: clinical record review for the resident, observations, and staff interviews.

WRITTEN NOTIFICATION: Based on Assessment of Resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 fall prevention care set out in the plan of care was provided to the resident as specified in the plan. The resident was observed in bed without the use of a fall prevention strategy and the care plan documented the intervention was to be used at all times. A Personal Support Worker verified the intervention was not provided as planned.

Sources: clinical record review for the resident, observations, and staff interviews.

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

A) The licensee failed to ensure that the outcomes of the care set out in the plan of care related to fluid intake was documented.

The resident was monitored for fluid intake as part of the care tasks identified in Point of Care (POC). Personal Support Workers were to offer additional fluids each shift and report any signs or symptoms of dehydration. The Assistant Director of Care verified there was missing documentation in POC related to fluid intake on specific dates and shifts as well as routine intake of fluids at meals and snacks at specific times. The incomplete documentation of daily fluid intake and the accumulative fluid intake calculations would have provided information to the nursing staff and Registered Dietitian in order to assess the resident's hydration needs.

Sources: clinical record review for the resident and staff interviews.

B) The licensee failed to ensure that the outcomes of the care set out in the plan of care related to the use of a fall prevention strategy was documented.

The resident was observed in bed without the use of a fall prevention strategy and the care plan documented the intervention was to be used at all times. A Personal Support Worker verified the intervention was not provided as planned. PSWs documented in Point of Care that fall/injury prevention strategies were in place when the intervention was not used.

Sources: clinical record review for the resident, observations, and staff interviews.

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A written complaint was emailed to the Director of Care (DOC) identifying care concerns related to pain management for a resident. The electronic Medication Administration Record (eMAR) was reviewed to determine effectiveness of as needed (PRN) medication administration. On multiple dates pain medication was ineffective in relieving the resident's pain. The DOC verified the Pain Assessment/Sedation Score in Point Click Care was the clinically appropriate assessment specifically designed to assess pain, and the resident was not assessed

using this instrument. An assessment of the resident's pain would be used to determine effective management. The completion of the pain assessment would have provided a comprehensive understanding of the resident's pain, including intensity, location, and impact on daily activities to ensure an effective care plan to relieve pain and discomfort.

Sources: clinical record review for the resident and interview with the Director of Care.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, section 9.1 (b) of the IPAC Standard states that at minimum routine practices include hand hygiene before and after resident environment contact. A housekeeper was seen collecting garbage bags, and touching door handles of the boardroom, offices, and reception desk all while wearing the same pair of gloves, with no hand hygiene. A resident had earlier been seen in the same area utilizing some of the same spaces.

Sources: Observations of staff and residents

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

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:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that the written complaint made to the licensee concerning the care of a resident was investigated and resolved where possible, and a response that complied with paragraph 3, was provided in receipt of the complaint, and where the complaint alleged risk of harm the investigation was commenced immediately.

A written complaint was emailed to the Director of Care (DOC). Although Assistant DOC investigated the complaint immediately, there was no investigation documentation, specific interviews or follow up that included all the concerns. The response to the complainant did not include an explanation of what the licensee did to resolve the complaint related to the allegation or whether the response to the complaint was founded or unfounded together with the reasons for the belief related to the concern. The documented record titled, "Response to Complaints - Complaint Record Form" had no documentation related to the "Final Resolution".

Sources: review of the Response to Complaints - Complaint Record Form, Complaint Follow Up Interview with Registered Practical Nurse, complaint email

and manager response email, and ADOC and Staff interview.

WRITTEN NOTIFICATION: Security of Drug Supply

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that the vaccine storage fridge in the Charge Nurse office was kept locked at all times when not in use. The pad lock on the fridge was noted to be off the latch in the unlocked position where multiple vaccines were stored. The office was unattended. The Registered Nurse (RN) was unsure as to why or for how long the fridge had been unlocked for.

Sources: RN Interview, and observation of the vaccine storage fridge.

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that pain medication was administered to the resident every two hours as needed (PRN) when pain management was ineffective.

The electronic Medication Administration Record (eMAR) was reviewed to

determine effectiveness of PRN medication administration. On two separate dates the resident was not administered pain medication as prescribed when the previous dose was ineffective. If the resident was monitored and screened earlier, the next dose could have been administered as prescribed and not over three hours later. The Director of Care verified there was opportunity to administer pain medication as prescribed for pain and comfort.

Sources: clinical record review for the resident and interview with the Director of Care.