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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 10, 2023
Original Report Issue Date: June 7, 2023
Inspection Number: 2023-1122-0001 (A1)
Inspection Type: Complaint Post-Occupancy Critical Incident System
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Meaford LTC, Meaford

Amended By	**Inspector who Amended Digital Signature**
Gabriella Del Principe (741734)	Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.08.14 10:48:16 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Change the Inspection number from #2023-1693-0001 to Inspection #2023-1122-0001

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Lead Inspector Gabriella Del Principe (741734)	**Additional Inspector(s)** Katy Harrison (766)
Amended By Gabriella Del Principe (741734)	**Inspector who Amended Digital Signature** Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.08.14 10:47:32 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Change the Inspection number from #2023-1693-0001 to Inspection #2023-1122-0001

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 11-12, 15-19, 23-26, 29-31, 2023 and June 1, 2023.

The following intakes were inspected in this complaint inspection:
- Intake: #00021831 was related to resident care.
- Intake: #00022239 was related to multiple care concerns.

The following intake was completed in this post-occupancy inspection:
- Intake: #00087599

The following intakes were inspected in this Critical Incident (CI) inspection:
- Intake: #00087342 was related to falls prevention and management.
- Intake: #00019274 was related to alleged staff to resident abuse.

The following intakes were completed in this inspection: Intake #00019653 and Intake #00019171 were related to falls.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from physical abuse by a staff member.

Rationale and Summary

Two Personal Support Workers (PSW) were providing care to a resident, when the resident began to demonstrate responsive behaviours. In response to the resident's responsive behaviours, one PSW acted inappropriately towards the resident.

The resident had a history of responsive behaviours, and their care plan specified strategies to promote an optimal interaction.

Failure to utilize the strategies documented in the resident's care plan and protect them from abuse, resulted in the resident sustaining an injury.

Sources: Critical Incident; Resident's clinical health record; Interviews with Registered Practical Nurse's (RPN) and Director of Care (DOC). [741734]

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee failed to immediately notify the police of a staff to resident abuse.

Rationale and Summary

There was an incident of physical abuse from a PSW towards a resident, as referenced in NC #001. The police were not notified of this incident of abuse by the PSW.

By failing to inform the police, it prevented them from investigating and taking action.

Sources: Critical Incident; Resident's clinical health records; Interview with DOC. [741734]