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: December 8, 2023

Inspection Number: 2023-1122-0004

Inspection Type:
Complaint
Critical Incident

Licensee: peopleCare Communities Inc.

Long Term Care Home and City: peopleCare Meaford LTC, Meaford

Lead Inspector	**Inspector Digital Signature**
Tanya Murray (000735)	

Additional Inspector(s)
Diane Schilling (000736)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20-24, 28-29, 2023

The following critical incident intake(s) were inspected:

- Intake #00099043/CI#3062-000021-23 was related to responsive behaviours; and
- Intake #00102354/CI#3062-000027-23 and Intake #00098458 /CI#3062-000017-23 was related to prevention of abuse and neglect

The following complaint was inspected:

- Intake: #00097063 was related to skin and wound prevention and management

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dining and snack service

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure proper techniques to assist a resident with eating.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that they follow their strategy when there are concerns regarding the proper techniques to feed a resident.

Rationale and Summary
The dietician stated that the home should provide education to ensure individuals are properly feeding residents. If there are any concerns with safety, the dietician

will provide further training to ensure that the individual is safely feeding a resident.

The home had allowed a resident to assist another resident with their meals. There were concerns documented that the resident was being force fed on multiple dates.

A referral was made to the dietician and the resident assisting with feeding was educated on proper techniques.

The dietician stated that the risks of force feeding a resident include choking, aspiration, emesis and decreased enjoyment of their meal.

The resident was not trained on safe feeding techniques until the fourth time force feeding was observed.

By not providing the proper technique during meals the resident was at risk of harm.

Sources: Clinical records, observations, interviews with staff.
[000736]

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care

Rationale and Summary
A resident had new wounds discovered. The SDM had not been notified when there was a change in the resident's skin condition. The new altered skin and wound integrity assessment stated that the POA/SDM must be notified of any new skin concerns.

The skin and wound lead confirmed that the SDM had not been notified when there was a significant change in the resident's skin integrity, but should have been. The SDM did not become aware of the wounds until the resident was admitted to the hospital where they were alerted by the physician in the emergency department.

Failure to notify the POA in changes in a resident's condition prevents their ability to participate fully in the development and implementation of the resident's plan of care.

Sources: Clinical records, interview with staff
[000735]

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)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by use of force by another resident that caused physical injury.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
A resident secured another resident's hand's in such a way they could not move them. In trying to remove the restriction the resident had pain.

A skin assessment was completed which included photos of the resident's wrists, identifying marks and bruises which were the result of the incident.

The PSW who responded to the incident indicated the resident was voicing complaints of pain.

Failure to protect from abuse caused harm to the resident.

Sources: Clinical records, skin assessments, photographs, and interview with resident
[000735]

WRITTEN NOTIFICATION: Skin and Wound Prevention and Management

NC #003 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
A RPN completed a new altered skin integrity assessment of a resident's new wounds. Immediate treatment or interventions were not provided until several days later by the skin and wound lead. The resident was admitted to the hospital, where the wounds were treated.

The skin and wound lead confirmed that the registered staff did not implement treatment when a new wound was discovered.

Failure to implement treatment and interventions could delay healing and lead to infection.

Sources: Clinical records, interview with staff, Skin and Wound Care Management Policy
[000735]

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #004 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 failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control is followed.

Specifically, in the COVID-19 Guidance Document for Long-term Care Homes in Ontario states that masks are required to be worn in all resident areas indoors for staff, students, volunteers and support workers.

Rationale and Summary
A staff member was observed by an inspector not wearing a mask correctly. The inspector spoke to the staff member and inquired about wearing a mask on resident units. The staff member stated that they only needed to put their mask on properly when they were directly interacting with residents.

The staff member was observed again standing near a resident's room not wearing their mask appropriately and they corrected it when they saw the inspector on the unit.

When staff do not follow masking requirements there is risk for the spread of respiratory infections.

Sources: Observations,, COVID -19 Guidance Document for Long-term Care Homes in Ontario
[000736]