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

Original Public Report

Report Issue Date: September 18, 2024
Inspection Number: 2024-1122-0004
Inspection Type:
Complaint
Critical Incident

Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Meaford LTC, Meaford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 19-23, 26-30, 2024

The following intake(s) were completed in this critical incident inspection:
- Intake #00121322 and intake #00121366 were related to responsive behaviours and prevention of abuse and neglect.

The following intake(s) were completed in this complaint inspection:
- Intake #00122843 was related to prevention of abuse and neglect;
- Intake #00117421 was related to medication management, falls prevention and management, care and support services, and continence care and bowel management.

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

Continence Care
Resident Care and Support Services
Medication Management

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
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 (5)
Plan of care
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 made aware of changes of the resident's plan of care.

Rationale and Summary
The SDM had not been notified when there was a change in the resident's medications or test results.

Failure to notify the SDM of changes in a resident's medications and to obtain consent for treatment, could limit them from fully participating in the development and implementation of the resident's plan of care.

Sources: Clinical records, interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Management

NC #002 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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The home failed to ensure that a resident received 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 after an altercation with a co-resident.

Rationale and Summary
A resident sustained skin lacerations. A clinically appropriate assessment tool had not been completed for any of the lacerations until several days after the incident.

The staff confirmed that a new altered skin and wound integrity assessment should have been completed for each laceration after the incident, or upon the resident's return to the home. A clinically appropriate assessment tool was not completed until several days later.

Failure to have complete an assessment using a clinically appropriate assessment tool could lead to lack of monitoring.

Sources: Clinical records, interview with staff, and the home's skin and wound management policy.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents through identifying factors that could potentially trigger such altercations.

Rationale and Summary
A resident had altercations with co-residents. The home was aware the of the resident's responsive behaviours.

Several staff stated that the resident had identified triggers. They acknowledged

that the types of responsive behaviours demonstrated by the resident, as well as possible triggers, were not added to the resident's care plan after the first altercation but should have been.

Failure to ensure that appropriate steps were taken to minimize the risk of altercations and protect the safety of residents lead to additional altercations and injuries.

Sources: The home's policy for responsive behaviours, clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

As per the home's transferring residents from a secure to a non-secure unit policy, the accompanying checklist was to be completed throughout the process of

transferring a resident but was not.

Rationale and Summary
A resident was admitted to the home's secure unit.

The home's policy, transferring residents from a secure to a non-secure unit, stated that the checklist is to be completed throughout the process of moving a resident. This checklist provided step by step instructions for the multidisciplinary team to confirm the resident's appropriateness for the transfer, and what actions to take prior to and after the transfer. It was to be signed by the Director of Care (DOC) or designate after review for completion.

Staff confirmed that the the checklist was not completed prior to transferring the resident off the home's secure unit.

By failing to comply with their own policy and checklist prior to transferring the resident off their secure unit, put the resident and their co-residents at risk harm.

Sources: Clinical records, the home's transferring residents from a secure to a non-secure unit policy, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

As outlined in the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 7.3 (b) stated that the IPAC lead is responsible for ensuring that audits are performed, at least quarterly, to ensure that all staff can perform the IPAC skills required for their role.

The licensee failed to ensure that the IPAC lead completed these audits as required.

Rationale and Summary
Multiple IPAC audits were reviewed during the inspection; however, the home's IPAC lead confirmed they do not have, nor complete, role-specific audits for IPAC related tasks for staff. They also confirmed that the home is not completing audits of high touch surface area cleaning.

By failing to complete the IPAC audits as required by the IPAC Standard, there was risk of staff not performing their IPAC duties properly.

Sources: Interview with staff.

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate

police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of the physical abuse of a resident.

Rationale and Summary
An incident occurred in the home which resulted in an injury to a resident.

The staff confirmed they did not contact police immediately after the incident but should have.

By failing to notify the police service immediately, there may have been a delay in the police's ability to respond to the incident in a timely manner.

Sources: Clinical records, the home's abuse or suspected abuse/neglect of a resident policy, and interview with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the Licensee must:
a) Provide education on the home's Responsive Behaviours and Prevention of Abuse and Neglect policies to all registered staff that work on Orchard View. This education must include identifying triggers, prevention strategies, expectations related to care plan revisions when responsive behaviours/triggers/interventions are identified, and actions to take after a resident to resident physical altercation. Keep a documented record of the date and time, as well as a list of those who attended the meeting. Provide the documented records upon request of the inspector.
b) Develop an auditing tool to use after a resident to resident physical altercation, to ensure registered staff are completing the items listed in section A.
c) Assign a staff member(s) who will be responsible for auditing resident care plans following all resident to resident physical altercations.
d) Audit all resident to resident physical altercations for one month using the newly developed auditing tool. Keep a documented record of the results of the audit and actions taken.

Grounds
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.

a) The licensee has failed to ensure that a resident was protected from physical abuse by a co-resident.

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; (“mauvais traitements d’ordre physique”)”.

Rationale and Summary

A resident to resident altercation occurred that resulted in a resident being injured.

Staff called a “code white” and additional staff arrived to provide assistance.

Failure to protect residents from harm could jeopardize their safety and cause injuries.

Sources: Clinical records, interviews with staff.

b) The licensee has failed to ensure that a resident was protected from physical abuse by a co-resident.

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; (“mauvais traitements d’ordre physique”)”.

Rationale and Summary
A resident received an injury after an altercation with another resident.

The Director of Resident Care stated the home had a duty to protect both residents from harm.

This incident of physical abuse caused moderate impact to a resident as they experienced pain and injury as a result of the incident.

Sources: Clinical records, interviews with residents and staff.

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This order must be complied with by December 16, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Issued four times:
2023-06-07, Written Notification, #2023-1122-0001
2023-12-08, Written Notification, #2023-1122-0004

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2024-03-15, Written Notification, #2024-1122-0001
2021-10-20, Compliance Order High Priority, #2021_836766_0017 (LTCHA 2007 S.O. 2007, c.8 s. 19)

No previous AMPs within CH.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.