

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

Public Report

Report Issue Date: July 14, 2025

Inspection Number: 2025-1122-0003

Inspection Type:

Complaint
Critical Incident

Licensee: peopleCare Communities Inc.

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

INSPECTION SUMMARY

Inspection Summary

The inspection occurred onsite on the following date(s): July 8 - 10, 2025.

The following intake(s) were inspected:

- Intake: #00148581, Critical Incident (CI) #3062-000010-25: related to outbreak management.
- Intake: #00149225 related to concerns regarding an allegation of delayed intervention and treatment of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

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WRITTEN NOTIFICATION: General Requirements

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to take prompt action, document assessments, or interventions, when a resident was exhibiting signs and symptoms of an acute medical condition.

A resident was exhibiting signs and symptoms of an acute medical condition. The home did not put interventions in place, call the Physician or document all assessments completed until seven hours later when the next shift reported for duty and completed additional assessments. The residents' condition had deteriorated in that time and required additional assessment, treatment and admission to an acute care hospital.

Sources: review of progress notes, quarterly minimum data set (MDS) assessments, point of care documentation, interviews with personal support workers (PSW), and Registered Nurses (RN).

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

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- s. 55 (2) Every licensee of a long-term care home shall ensure that,
- (a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
 - (ii) upon any return of the resident from hospital, and

The licensee failed to ensure that when a resident returned from the hospital, that a skin assessment was completed by an authorized person.

A resident had been admitted to the hospital for seven days. When they were re-admitted to the home, a skin assessment was not completed.

Sources: review of a resident's progress notes, head to toe assessment and interview with a RN.