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

Public Report

Report Issue Date: March 28, 2025
Inspection Number: 2025-1489-0002
Inspection Type: Critical Incident
Licensee: peopleCare Not-For-Profit Homes Inc.
Long Term Care Home and City: peopleCare A.R. Goudie Kitchener, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20, 24-28, 2025

The following intake(s) were inspected:
- Intake: #00135904 related to an incident of resident-to-resident abuse
- Intake: #00141541 related to a fall of a resident resulting in injury

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 failed to ensure that a resident was protected from abuse by a co-resident.

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

On a specified date, a resident hit another resident with a piece of equipment, resulting in the resident becoming upset.

Sources: Critical incident report, resident progress notes, interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an incident of abuse of a resident was immediately reported to the Director.

During an evening shift, an incident of abuse toward a resident occurred and the on-call nurse was made aware. The on-call nurse did not immediately report the incident to the Director as required.

Sources: Critical incident report, interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that the falls prevention and management program provided for the use of equipment, supplies, devices and assistive aids for a resident.

A resident required the use of equipment to be in place for a falls intervention. The equipment required for the resident was not implemented as per their plan of care upon observation.

Sources: Resident care plan, observations, interview with staff.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

1.Review and revise the home's Responsive Behaviours program as needed to:
a) Direct staff as to when a referral for a resident exhibiting responsive behaviours is required, and to whom the referral shall be made.
b) Direct staff as to which actions, including assessment and reassessment tools, are to be used for a resident who is demonstrating responsive behaviours and when each of these tools are to be completed.
2.Provide all registered staff and any other staff involved in BSO processes with education on the revised processes in Part 1. The education shall be documented including the contents of the education, who is providing the education, names of staff receiving the education, and the date(s) and time(s) of the education. Ensure these records are provided to an Inspector upon request.
3.Provide all registered staff with communication regarding resident-to-resident altercations, and how responsive behaviours may increase the risk of resident-to-resident abuse and the role of registered staff in addressing such situations. Maintain a record of the communication provided to staff and ensure the record is provided to an Inspector upon request.

Grounds

The licensee failed to ensure that actions were taken to respond to the needs of a resident, including assessments, reassessments, and interventions when they were demonstrating responsive behaviours.

On multiple occasions a resident demonstrated responsive behaviours toward different co-residents. Staff were aware of incidents involving the resident demonstrating responsive behaviours toward other residents. Appropriate referrals or assessments of the resident were not completed in a timely manner.

Sources: Critical incident report, resident progress notes and care plan, interviews with staff.

This order must be complied with by May 9, 2025

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.