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

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Original Public Report

Report Issue Date: December 15, 2022

Inspection Number: 2022-1462-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: peopleCare Communities Inc.

Long Term Care Home and City: peopleCare Oakcrossing London, London

Lead Inspector	**Inspector Digital Signature**
Rhonda Kukoly (213)	Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2022.12.19 08:56:33 -05'00'

Additional Inspector(s)
Susan Crann (741069)
Cassandra Aleksic (689)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 2022

The following intake(s) were inspected:

- Intake #00001422, a complaint related to a fall
- Intake #00001477, critical incident #2980-000014-22, related to a fall
- Intake #00004209, a complaint related to bathing
- Intake #00004911, critical incident #2980-000013-22, related to an altercation between residents
- Intake #00005868, critical incident #2980-000009-22, related to a fall
- Intake #00008624, critical incident #2980-000021-22, related to a fall
- Intake #00008639, critical incident #2980-000022-22, related to a fracture of unknown origin
- Intake #00012474, critical incident #2980-000027-22, related to a fall
- Intake #00013055, an anonymous complaint related to various care concerns
- Intake #00014256, critical incident #2980-000030-22, related to an incident of alleged abuse
- Intake #00014447, a complaint related to an altercation between a visitor and a resident

The following Inspection Protocols were used during this inspection:

Continence Care
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with FLTCA, 2021, s. 6 (6)

The licensee has failed to ensure that when a resident was admitted, an initial plan of care was developed based on the assessment, reassessments and information provided by the placement coordinator.

A complaint was received by the Ministry of Long-Term Care, which outlined concerns related to Infection Prevention and Control (IPAC). The resident's care plan identified that the resident may have had potential for IPAC concerns. The information was created in the care plan upon the resident's admission to the home.

The IPAC lead stated that they had reviewed the resident's admission documentation from the Home and Community Care Support Services (HCCSS) which identified that the concern was resolved and treated prior to admission. When asked if the resident's current plan of care was up to date, the IPAC lead stated no, and updated the care plan. The risk to the resident was low.

Sources: Health records for a resident, and staff interview.

Date Remedy Implemented: November 21, 2022 [689]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021, s. 6 (1)(c)

The licensee has failed to ensure the written plan for care a resident provided clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
An anonymous complaint was received by the Ministry of Long-Term Care, that included a concern related to the monitoring and treatment for a resident's specific diagnosis.

The plan of care for the resident did not include clear direction related to monitoring and treatment for a specific diagnosis. A personal support staff said it is their role is to observe residents during care, they would rely on the kardex and care plan for direction on what to observe for, and report to the registered nursing staff. There was risk to the resident that staff may not identify and then address the signs of a concern specific to a diagnosis in the resident, without clear direction.

Sources: An anonymous letter of complaint, health records for a resident, and staff interviews. [741069]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that two written complaints received concerning the care of two residents, were immediately forwarded to the Director.

Rationale and Summary
a) The Ministry of Long-Term Care (MLTC) received a complaint related to care concerns. The complainant reported that they had informed the home of their concerns.

The home's complaint/response logs identified that a Complaint Record Form was completed related to the complaint that was received via email. The written complaint and response regarding the care of the resident was not forwarded to the Director via the MLTC Critical Incident System. The Assistant Director

of Care (ADOC) stated that the home did not report the written concern to the Director, and they would expect that a copy of the complaint and response made should have been submitted.

b) On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 22 (1) of the LTCHA.

An anonymous complaint was received by the Ministry of Long-Term Care, which outlined concerns related to another resident's care. The home's complaint/response log included a Complaint Record Form, which indicated the complaint was a written complaint received prior to April 11, 2022, and a response provided to the complainant was documented. This written complaint and response were not forwarded to the Director via the MLTC Critical Incident System.

The home's Response to Complaints policy stated that the Ministry of Health and Long-Term Care (MOHLTC) shall be notified of any written complaints and that a complaint received via e-mail was considered a written complaint.

Sources: Complaint Record Forms for two residents, the home's Response to Complaints policy, and staff interviews. [689]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021, s. 27 (1) (a) (iii)

The licensee has failed to ensure that an injury of unknown cause was immediately investigated.

O. Reg 246/22 s. 115 (3) states: The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Rationale and Summary
The home reported in a critical incident indicating that a resident had a change in condition and was found to have an injury.

The Director of Care (DOC) said that they and the staff assumed that the resident had an unwitnessed fall that caused the injury and as a result of that assumption, no investigation was completed. There was

risk that the injury was caused by something other than a fall that was not investigated, not identified and not acted on.

Sources: A Critical Incident Report, health records for a resident and staff interviews. [213]

WRITTEN NOTIFICATION: Reports of investigation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021, s. 27 (2)

The licensee has failed to report to the Director, the results of an investigation undertaken related to an incident that caused an injury to a resident for which the resident was taken to hospital that resulted in a significant change in the resident's health status.

Rationale and Summary
The home reported a critical incident report regarding an incident that resulted in injury to a resident. The report was last amended the day after the incident by the previous Executive Director (ED), regarding long-term actions planned to correct this situation and prevent recurrence. The long-term actions stated: training as needed depending on outcome of investigation. The home's internal investigation records included communication 11 days after the incident, indicating that the investigation and follow up was not completed.

The previous Acting DOC said that the expectation was that the person who submitted the critical incident report would amend the report with the outcome of the investigation.

Sources: A Critical Incident Report, health records for a resident and staff interviews. [213]

WRITTEN NOTIFICATION: Air temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 24 (2)

The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms, in different parts of the home, one resident common area on every floor, and every designated cooling area of the home.

Rationale and Summary
An anonymous complaint was received by the Ministry of Long-Term Care, which outlined heat concerns in the building and residents having signs and symptoms of heat related illness.

The measured and documented temperature records were provided by maintenance staff, who stated that they had completed the temperature checks for the dining room and nursing station in each of the five home areas, and the housekeeping staff measured and documented temperatures for the resident rooms.

The temperature records showed incomplete documentation for the five home areas, as weekend temperatures were not completed for the dining rooms and nursing stations, not all designated cooling areas were measured and documented, and resident bedrooms had incomplete documentation. There were no temperature records completed for the five home area dining rooms and designated cooling areas from September to November 2022. There were no records completed for resident bedrooms in three of the five home areas from September to November 2022, and two of the five home areas for November 2022.

Over the course of approximately four months the residents in the home may have been impacted by heat-related illness as the temperatures in designated cooling areas were not measured or documented. This may have increased the risk to residents as the home may not have implemented their heat-related illness prevention and management plan.

Sources: Documented temperature records, Heat Related Illness Prevention and Management Plan, and staff interviews [689]

WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the temperature required to be measured in specified areas of the home (at least two resident bedrooms, one common area, and every designated cooling area) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
An anonymous complaint was received by the Ministry of Long-Term Care, which outlined heat concerns in the building and residents having signs and symptoms of heat related illness.

The documented temperature records from June to October 2022, showed that the dining room and nursing station in each of the five home areas were recorded once daily in the morning hours from June to August 2022. The temperature records were incomplete as they were not measured or documented in the afternoon between 12 p.m. and 5 p.m., once every evening or night, and were not documented

on the weekends. The temperature records for resident rooms in each of the five home areas were incomplete as they were not measured or documented once in the evening or night, and some dates had no documentation or partial documentation.

The Executive Director (ED) stated that if temperatures were not measured or documented, then the home would not know when to implement the heat-related prevention and management plan.

Sources: Documented temperature records, Heat Related Illness Prevention and Management Plan, and staff interview. [689]

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 24 (4)

The licensee has failed to ensure that for every resident bedroom that is not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

Rationale and Summary
An anonymous complaint was received by the Ministry of Long-Term Care, which outlined heat concerns in the building and residents having signs and symptoms of heat related illness.

The documented temperature records for resident rooms in all five home areas from June to October 2022 had incomplete documentation including missing dates and times.

The Executive Director (ED) stated that not all resident rooms were serviced by air conditioning between May and September 2022. When asked if the temperatures were measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m., in every resident bedroom that was not serviced by air conditioning, the ED stated that the documentation was inconsistent and incomplete, and they would expect that they would have been measured and documented each day at the designated times as required.

Over the course of approximately four months the residents in the home may have been impacted by heat-related illness as the temperatures in resident bedrooms were not measured or documented. This may have increased the risk to residents as the home may not have implemented their heat-related illness prevention and management plan.

Sources: Documented temperature records, Heat Related Illness Prevention and Management Plan, and staff interview. [689]

WRITTEN NOTIFICATION: Bathing

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary
The Ministry of Long-Term Care received a complaint related to missed baths for a resident.

A personal support worker staff member stated that residents should be bathed at a minimum, twice per week, by the method of their choice. They said that the information would be documented in Point of Care (POC) and if staff were not able to complete a bath, then the registered staff were informed and would document a progress note to track missed or refused baths. The bathing records for the resident identified that there was no bathing documentation on four dates. There was no documentation indicating that a make-up bath was provided for three of the dates.

Sources: Health records for a resident, complaint/response documentation, and staff interviews. [689]

WRITTEN NOTIFICATION: Falls prevention and management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg 246/22, s. 54 (2)

The licensee has failed to ensure that when staff assumed a resident had fallen, the resident was assessed, including head injury routine, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary
The home reported a critical incident report regarding an incident that resulted in injury to a resident. Progress notes for the resident and investigation records indicated that a resident had a change in condition and was found to have another injury.

The Assistant Director of Care (ADOC) and Director of Care (DOC) said that they assumed that resident had unwitnessed falls causing the injuries. There were no post fall assessments or head injury routines completed for the resident. The DOC said that if staff assumed that the resident had unwitnessed falls that caused the injuries, post fall assessments and head injury routine should have been completed.

There was risk that the resident could have had other injuries, including head injuries, that were not assessed and therefore not addressed if they had unwitnessed falls.

Sources: A Critical Incident Report, internal investigation records, health records for a resident, the Fall Prevention & Management Program – Falls Risk Factors & Related Interventions policy #005190, Falls Management Algorithm and staff interviews. [213]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that two residents, who had altered skin integrity, received skin assessments by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
a) The Ministry of Long-Term Care received an anonymous complaint, indicating that a resident was not receiving appropriate skin and wound care.

A resident had three areas of altered skin integrity identified on admission, the first assessment of the areas were completed 14 days after admission for two of the areas and 24 days after admission for one area. The three areas deteriorated between the time of admission and the time of assessment. [7411069]

b) The home reported a critical incident regarding an incident that resulted in altered skin integrity for a resident.

The first assessment of the altered skin integrity was completed 14 days after the incident. There was risk that the wound could have worsened and not received appropriate treatment when it was not assessed. [213]

Sources: A Critical incident report, an anonymous complaint, health records for two residents, the home's Skin and Wound Care Management Program #006020.00, and staff interviews.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident who had altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rationale and Summary
The Ministry of Long-Term Care received an anonymous complaint, indicating that resident was not receiving appropriate skin and wound care.

A resident had three areas of altered skin integrity identified on admission, that deteriorated over a three-week period. Health records for the resident indicated that there were no interventions or treatment for the areas in the resident's plan of care over the three-week period.

Sources: Anonymous complaint, health records for a resident, the home's Skin and Wound Care Management Program #006020.00, and staff interviews. [741069]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident who had altered skin integrity, received weekly skin and wound assessments by a member of the registered nursing staff.

Rationale and Summary
The Ministry of Long-Term Care received an anonymous complaint, indicating that resident was not receiving appropriate skin and wound care.

The resident had four areas of altered skin integrity identified on admission, there were no weekly assessments completed for any of the areas after the initial assessments were completed and found to have deteriorated since admission.

Sources: Public complaint, health records for a resident, the home's Skin and Wound Care Management Program #006020.00, and staff interviews. [741069]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg. 246/22 s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed of a significant injury to a resident of unknown cause.

Rationale and Summary
Progress notes for the resident and investigation records indicated that a resident had a change in condition and was found to have an injury.

The Assistant Director of Care (ADOC) did an investigation and assumed the resident had an unwitnessed fall causing the injury. The ADOC didn't report the incident as a critical incident to the Ministry of Long-Term Care because they were unaware of that requirement at that time.

Sources: Health records for resident and staff interviews**.** [213]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with FLTCA, 2021, s. 24 (1)

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

a) Review and revise, if necessary, the home's process for obtaining, transcribing, and processing medical directives. Keep a record of the date of the review, who participated, and changes made.

b) Provide training for all registered nursing staff on one unit, including the charge nurse and Assistant Directors of Care, regarding the home's process for blood work ordered in medical directives, the signs and symptoms of a specific diagnosis, and accountabilities in ensuring that residents have appropriate blood work and monitoring as applicable. Keep a record of the training, the staff who completed the training and dates completed.

c) Provide training for a physician and a registered dietitian, regarding the home's process for quarterly reviews for residents who have a specific diagnosis and accountabilities in ensuring that residents have appropriate blood work and monitoring as applicable. Keep a record of the training, the staff who completed the training and dates completed.

d) Perform an audit of medical directives and physician's orders for residents with a specific diagnosis to ensure they have been processed and are being completed as applicable. Document the audit completed, dates, person completing, and actions taken to correct any deficiencies.

e) Perform a monthly audit of newly admitted residents with a specific diagnosis to ensure the process for medical directives and processing physician's orders is being followed and that the plan of care includes relevant monitoring. Document the audit completed, dates, person completing, and actions taken to correct any deficiencies.

Grounds
Non-compliance with FLTCA, 2021, s. 24 (1) and with LTCHA 2007, s. 19 (1)

The licensee has failed to ensure that a resident was protected from neglect.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred after April 11, 2022, where the requirement was under s. 24 (1) of the FLTCA. Non-compliance with the applicable requirement also occurred prior April 11, 2022, which falls under s. 19 (1) of the LTCHA, 2007.

Section 7 of the Ontario Regulation 246/22 and section 5 of the Ontario Regulation 79/10 defines neglect as: the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well -being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rational and Summary
An anonymous complaint was received by the Ministry of Long-Term Care that included a concern related to a resident with a change in condition and not having the appropriate testing and monitoring completed in the home for over one year.

Non-compliance with LTCHA 2007, s. 19 (1)

Health records for the resident showed that the physician ordered testing and monitoring for the resident that was specific to their medications and specific diagnosis. The orders were not processed appropriately, and the resident did not have the appropriate testing or monitoring specific to their diagnosis and ordered medications for over a year. The plan of care for the resident did not include clear direction related to monitoring and treatment for a specific diagnosis.

Four three-month medication reviews and three quarterly dietary assessments were completed and did not include any orders for any testing or monitoring specific to their diagnosis and ordered medications.

There were no testing, monitoring or results in the resident's health record for an 11 month period.

Non-compliance with FLTCA, 2021, s. 24 (1)

A resident had a specific diagnosis and medications ordered that require regular testing and monitoring. The plan of care for the resident did not include clear direction related to monitoring and treatment for a specific diagnosis.

A quarterly dietary assessment indicated no recent lab work since last assessment, the diagnosis was controlled, but was not monitored. A dietary progress note stated the diagnosis was controlled on their ordered diet and was not on medications for that diagnosis. A three-month medication review indicated recommendations from pharmacy to complete testing and monitoring, given the most recent results were from over a year ago.

There were no testing, monitoring or results in the resident's health record for another three-month period. The resident's condition deteriorated requiring hospitalization and a change in medications.

The Executive Director (ED) and the Director of Care (DOC) said there was a gap in the method for processing medical directives in the home. The ED stated it was an expectation that there were regular testing and monitoring and medical directives from the physician were processed and completed as ordered. The ED and DOC said that they felt that they would consider it neglect that resident did not have the testing and monitoring specific to their diagnoses and medications for over a year.

Sources: An anonymous letter of complaint received by the MLTC, health records for a resident, Physician's Orders policy #010021.00, and staff interviews. [741069]

This order must be complied with by February 28, 2023

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.