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

London District
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Original Public Report

Report Issue Date: March 23, 2023

Inspection Number: 2023-1462-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: peopleCare Communities Inc.

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

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2023.03.30 08:01:48 -04'00'

Additional Inspector(s)
Rhonda Kukoly (213)
Cheryl McFadden (745)
Samantha Perry (740)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 6, 7, 8, 9, 13, 14, and 15, 2023
The inspection occurred offsite on the following date(s):
March 10, 2023

The following intake(s) were inspected:
Intake #00013908/Critical Incident System (CIS) #2980-000028-22 related to responsive behaviours.
Intake #00014765/CIS #2980-000032-22 related to alleged staff to resident abuse.
Intake #00015625/CIS #2980-000035-22 related to alleged staff to resident abuse.
Intake #00015836/CIS #2980-000036-22 related to resident to resident abuse.
Intake #00017172/CIS #2980-000039-22 related to alleged staff to resident abuse.
Intake #00017236/CIS #2980-000001-23 related to fall prevention.
Intake #00017283/Complaint #IL-08828-LO related to suspected staff to resident neglect.
Intake #00017514/CIS #2980-000002-23 related to alleged staff to resident incompetent care.
Intake #00017938/CIS #2980-000005-23 related to resident to resident abuse.
Intake #00018269/Complaint #IL-09220-LO related to suspected staff to resident neglect.
Intake #00018410/CIS #2980-000006-23 related to alleged staff to resident neglect.

Intake #00018540/Complaint #IL-09347-LO related to alleged staff to resident neglect.
Intake #00019738/Complaint #IL-10308-LO related to alleged staff to resident neglect and care.
Intake #00020930/CIS #2980-000008-23 related to alleged staff to resident abuse.
Intake #00021490/Complaint #IL-10552-LO related to alleged staff to resident abuse and neglect.
Intake #00021778/CIS #2980-000012-23 related to alleged staff to resident abuse.
Intake #00022096/CIS #2980-000014-23 related to alleged staff to resident abuse.

The following intakes were completed in this inspection:
Intake #00014550/CIS #2980-000031-22 related to resident care services.
Intake #00014857/CIS #2980-000034-22 related to fall prevention.
Intake #00021524/CIS #2980-000009-23 related to resident care services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) was found to be in compliance:
Compliance Order #001 from Inspection #2022-1462-0001 related to FLTCA, 2021, s. 24 (1) inspected by Rhonda Kukoly (213).

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 (1) (a)

The licensee has failed to ensure that there was a written plan of care that set out the planned care related to the use of a specific transfer aide for the resident.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to care concerns for the resident.

A review of the resident's clinical records showed no documentation of the specific intervention for turning and repositioning as part of the resident's written plan of care.

A progress note documented to ensure the use of the specific intervention to turn and reposition the resident. The resident also expressed they would feel safer during repositioning and turning if staff used the transfer aide requested.

On several dates, it was observed that the specific intervention was not used for the resident. Personal Support Workers said they were not sure where the specific intervention for turning and repositioning was and as a result had not used it when turning and repositioning the resident.

Sources: Resident's clinical records, observations, and interviews with staff.
[740]

WRITTEN NOTIFICATION: Plan of Care
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary:
The resident was observed at different times with a specific intervention in place. The Point Click Care (PCC) care plan documented a focus related to physiotherapy to use the specific intervention at specific times depending on clinical monitoring outcomes. There was no other nursing care plan intervention related to the use of the specific intervention for the resident.

There were three different as needed (PRN) physician orders related to the use of the specific intervention and clinical outcome monitoring was not completed consistently to ensure the specific intervention was effective in maintaining the resident's specific vital signs.

The Director of Care and the Executive Director reviewed the plan of care and verified the plan of care was not reviewed and revised when the resident's need for the specific intervention changed and when the resident started receiving the intervention continuously. The Registered Practical Nurse and Personal Support Workers could not provide further insight into how the resident came to use the specific intervention continuously. The resident did not have routine clinical monitoring to ensure the appropriate intervention administered was maintaining appropriate clinical outcomes.

Sources: observations of the resident, clinical record review of the resident, and interviews with staff.
[563]

WRITTEN NOTIFICATION: Housekeeping
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)

The licensee has failed to ensure that procedures were implemented as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, for the cleaning of the home including furnishings.

Rationale and Summary
Fixing Long-Term Care Act, 2021, s. 19 (1) (a) states, "Every licensee of a long-term care home shall ensure that there is an organized program of housekeeping for the home"

During an observation of a resident in the dining room, a PSW reported the dining room chairs were dirty and not routinely cleaned. Observation of the dining chairs verified they were heavily soiled.

The housekeeper and the PSW stated the chairs were hard to keep clean and they were stained, heavily soiled and management was aware of their condition.

The Director Support Services stated the chairs were not clean and in good condition and they should be.

The Director of Care (DOC) stated housekeeping cleans all of the dining room table legs and chairs using a disinfecting product on a monthly basis; PSWs were expected to wipe down any visibly soiled chairs as needed and inform housekeeping to sanitize the chair after it has been wiped down. The DOC verified the "Cleaning Frequencies Chart – Form" was the procedure in the home to identify the scheduled frequency related to cleaning "Dining Room Table Legs and Chairs" as monthly.

Sources: observations in the home, interviews with PSWs, a housekeeper and the Director Support Services.
[745]