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: May 15, 2023	
Inspection Number: 2023-1462-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Oakcrossing London, London	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2023.05.18 10:30:50 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14, 17, 18, 19, 2023.

The following intake(s) were inspected:

- Intake #00022062/CI#2980-000013-23 was related to falls prevention and management; and
- Intake #00083827 was related to resident care and support services.

The following intake(s) were completed in this inspection:

- Intake #00022860/CI#2980-000017-23 and intake #00084988/CI#2980-000018-23 were each related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls 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)
O. Reg. 246/22, s. 79 (1) 1.

The licensee failed to ensure that the dining service included, at a minimum, communication of the daily and seven-day menus to residents in one of the dining rooms during the lunch meal on April 18, 2023. During an observation by the Inspector, the meal that was served did not match the posted menus.

The following day, April 19, 2023, the daily and weekly menus had been updated and matched the meal which was served at lunch that day.

Sources: the posted daily and weekly menus and direct observation.

[721821]

Date Remedy Implemented: April 19, 2023

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) (b) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, that they received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
During care, a Personal Support Worker (PSW) staff noted and documented that a resident had a new skin concern. The Registered Practical Nurse (RPN) who was working stated that the PSW staff notified them of the new skin concern. The RPN stated that they did not perform an assessment of the new skin

concern that day. The following day, the skin concern worsened.

When interviewed, the RPN, the home's Administrator, and the Director of Care (DOC) each stated that the RPN should have assessed the new skin concern when it was brought to their attention, but that was not completed.

Sources: the resident's progress notes and care records, interviews with the RPN, the Administrator, and the DOC.

[721821]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The Licensee has failed to ensure that the Director was immediately informed in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the *Health Protection and Promotion Act*.

Rationale and Summary
O. Reg. 135/18 under the Health Protection and Promotion Act, 1990 states under s. 1 (a) that respiratory infection outbreaks in institutions and public hospitals were both diseases of public health significance and communicable in nature.

On April 14, 2023 an outbreak of Rhinovirus was confirmed by the Middlesex-London Public Health Unit (MLPHU) in one resident home area. By April 17, 2023 the outbreak had been confirmed in three additional home areas. The Director was informed of the communicable disease outbreak through the Critical Incident System (CIS) report on April 19, 2023 on CIS #2980-000024-23.

The Administrator and DOC stated they had been in regular contact with the MLPHU regarding the outbreak, however, they did not immediately notify the Director when the outbreak was confirmed.

Sources: CIS #2980-000024-23, and an interview with the Administrator and DOC.

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