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: September 27, 2023	
Inspection Number: 2023-1462-0005	
Inspection Type: Complaint Critical Incident	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Oakcrossing London, London	
Lead Inspector Debbie Warpula (577)	**Inspector Digital Signature** Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2023.09.28 16:29:03 -04'00'
Additional Inspector(s) Ali Nasser (523)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12, 13, 14, 18, 19, 21, 2023.

The following Critical Incident (CI) intakes were inspected:

- Intake #00094873/CI #2980-000060-23, related to a resident fall resulting in injury; and
- Intake #00093085/CI #2980-000056-23, related to allegations of resident neglect.

The following Complaint intake was inspected:

- Intake #00091997, related to concerns of alleged resident neglect, wound care and bathing.

The following intakes were completed in the CIS inspection: Intake #00090324/CI #2980-000039-23; Intake #00091231/CI #2980-000041-23; Intake #00092016/CI #2980-000058-23, related to falls resulting in injury.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

A review of a resident's plan of care showed fall prevention interventions.

Observations showed the resident in their bed and an intervention was not in place.

In an interview with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN), they said that the resident did not require the specific intervention anymore, but the plan of care was not yet updated to reflect this change.

In an interview the Falls prevention program lead said the resident was assessed at readmission to the home and it was determined that the specific intervention was no longer necessary but the plan of care was not yet revised.

The program lead confirmed the RPN had already reviewed and revised the plan of care.

Date Remedy Implemented: September 12, 2023.
[523]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii

The licensee has failed to ensure that a response entailing what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded, together with the reasons for the belief, after receiving a written complaint from a Power of Attorney (POA).

Rationale and Summary:
A resident's POA submitted a written complaint regarding the resident's care which was received by the home.

The home's policy "Response to Complaints" indicated that written or verbal complaints were investigated, and actions were taken for resolution. The Executive Director (ED) would ensure that the complainant would be notified of how the complaint would be resolved. If the complaint was believed to be unfounded, the ED would respond to the complainant indicating the reason for this belief.

In an interview with the ED, they indicated that the response to the complainant had not included what the licensee had done to resolve the complaint, or whether the complaint was believed to be unfounded, together with the reasons for the belief.

Sources: CI report, written complaint from a resident's POA, review of a resident's health care records, review of home's policy "Response to Complaints", interviews with a POA and ED.

[577]

WRITTEN NOTIFICATION: Resident Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident's right to care and services consistent with their needs was fully respected and promoted.

Rationale and Summary:
A CI report was received by the Director concerning alleged neglect related to medication administration.

In an interview with the ED they concluded from their investigation that during medication administration, the staff member had not provided the resident with the care they required.

The staff member not providing the resident with the assessment and care they needed during the incident placed the resident at risk.

Sources: CI report, review of a resident's health care records, review of home's policy "Abuse or suspected Abuse/Neglect" and "Medication Administration", the home's investigation notes, interviews with a POA, an RPN, DOC and ED.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a resident's family member, who made a complaint concerning the care of a resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:
A resident's POA submitted a written complaint regarding a resident's care which was received by the home.

The home's policy "Response to Complaints" indicated that a documented record would be kept in the home that included a response to the complainant, which included the contact information for the Ministry's Long-Term Care Family Support and Action Line, it's hours of service and contact information for the Patient Ombudsman.

In an interview with the ED, they advised that the response to the POA had not included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Sources: CI report, written complaint from a POA, review of a resident's health care records, review of home's policy "Response to Complaints", interviews with a POA and the ED.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint related to a resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary:
The home received a written complaint concerning alleged neglect of a resident via email.

The home's policy "Response to Complaints" indicated that a documented record would be kept in the home that included action taken to resolve the complaint including the date of action, time frames for action and any follow up.

In an interview with the ED, they advised Inspector #577 that they had not kept a documented record including the type of action taken to resolve the written complaint related to a resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

The home failed to keep a documented record putting a resident at risk.

Sources: CI report, written complaint from a POA, review of a resident's health care records, review of home's policy "Response to Complaints", interviews with a POA and ED.

[577]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution, if any, concerning the written complaint made regarding a resident.

Rationale and Summary:
The home received a written complaint concerning alleged neglect of a resident via email.

The home's policy "Response to Complaints" indicated that a documented record would be kept in the home that included the final resolution, if any.

In an interview with the ED, they advised Inspector #577 that they had not kept a documented record including the final resolution.

The home failed to keep a documented record that included the final resolution concerning the written complaint putting a resident at risk.

Sources: CI report, written complaint from a POA, review of a resident's health care records, review of home's policy "Response to Complaints", interviews with a POA and ED.
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