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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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 24, 2024	
Inspection Number: 2023-1462-0006	
Inspection Type: Complaint Critical Incident	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Oakcrossing London, London	
Lead Inspector Brandy MacEachern (000752)	**Inspector Digital Signature** Brandy MacEachern Digitally signed by Brandy MacEachern Date: 2024.01.31 09:19:09 -05'00'
Additional Inspector(s) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2, 3, 4, 5, 8, 9, 10, 11, 15, 16, and 17, 2024
The inspection occurred offsite on the following date(s): January 19, 2024

The following intake(s) were inspected:

- Intake: #00097046: Complaint related to resident's rights and choices
- Intake: #00098029 (CIS 2980-000068-23): related to alleged neglect of a resident
- Intake: #00099908 (CIS 2980-000074-23): related to alleged neglect of a resident
- Intake: #00100204: Complaint related to continence care
- Intake: #00100437: Complaint related to continence care
- Intake: #00101210 (CIS 2980-000078-23): related to alleged neglect of a resident
- Intake: #00101324 (CIS 2980-000080-23): related to the fall of a resident
- Intake: #00101364: Complaint related to the care and services provided to a resident
- Intake: #00101782: Complaint of alleged neglect to a resident

- Intake: #00104310 (CIS 2980-000087-23): related to the fall of a resident

The following intakes were completed as part of this inspection:

- Intake: #00097555 (CIS 2980-000065-23): related to the fall of a resident
- Intake: #00097874 (CIS 2980-000066-23): related to the fall of a resident

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO QUALITY CARE AND SELF-DETERMINATION

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

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

Rationale and Summary

A complaint was received by the Director regarding the collection of a sample for a resident.

The nurse who collected the sample used a method that resulted in the sample spilling on the resident.

During an interview with an Assistant Director of Care (ADOC), they said that the nurse did not collect the sample as expected, and outlined the proper steps that should have been taken.

The resident felt uncomfortable and upset when the sample spilled on them. The method of sample collection risked sample contamination and could have impacted subsequent medical treatment.

Sources: INFOLINE Complaint, and staff interviews.

[000753]

WRITTEN NOTIFICATION: Resident Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 21.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
21. Every resident has the right to have any friend, family member, caregiver or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

The licensee has failed to ensure that every resident has the right to have a family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

Rationale and Summary
A complaint was received by the Director concerning a resident's rights and choices.

In interview with the resident, they expressed that they had specific family members who they wished to have involved and informed of their care. During a record review of the resident's electronic chart, it was noted that the resident had a meeting on a specific date and one of the family members who had been identified by the resident was not in attendance at this meeting.

In an additional interview with the resident they informed they were not asked who they

wanted to invite to the meeting, as it was planned for them. The Executive Director (ED) informed that this family member had not been invited to join the meeting.

There was a risk to the resident that they would not have the family support they wished to have, when a meeting was conducted without all people of importance to the resident receiving an opportunity to attend the meeting.

Sources: Resident interviews, Staff interview, resident electronic chart.

[000752]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

The licensee failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to a resident related to a specific care area.

Rationale and Summary
During an inspection, inspector #000753 noted that a resident's clinical record, Kardex and Care Plan, stated that they preferred to have a specific care activity completed at a specific interval, on a certain day. However, the resident's schedule in their home area indicated that this care activity was to be completed on different days and intervals.

During interview with the home's Assistant Directors of Care (ADOCs), an ADOC said that the resident's care plan should have been updated by the nurses on the floor when their care plan changed.

The home's Care Plan and Plan of Care Policy stated that, each resident care plan and plan of

care will be up to date and reflect their current care needs, goals, and interventions, and be reviewed and revised in accordance with the Long-Term Care legislation.

By not updating the care plan and having two different care plans for the resident, staff could be confused, and therefore not provide the intended care.

Sources: Observation, clinical record, Home Care Plan and Plan of Care Policy Reference, and staff interviews.

[000753]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that any person designated by the resident is given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A complaint was received by the Director concerning a resident's rights and choices.

In interview with the resident, they expressed that they had specific family members who they wished to have involved and informed of their care. The resident's electronic chart did not reflect each of these family members as specified by the resident. In an interview with the Executive Director (ED) they advised that the information used for the resident's electronic chart, came from the Local Integrated Health Network (LIHN) at the time of the resident's

admission.

During the inspection, the ED documented in the progress notes a conversation they had with the resident, related to people of importance to the resident. The resident's electronic chart was updated by the ED to include the resident's wishes.

There was a risk to the resident that their plan of care may have been developed and implemented without the participation of all persons of importance to the resident, since their admission.

Sources: Interview with the resident, staff interviews, the resident's electronic chart.

[000752]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in their plan.

Rationale and Summary
During an inspection, Inspector #000753 observed a resident's home area schedule for a specific care activity, they were scheduled for the care activity at specific times and intervals.

The resident's clinical record, showed that the resident was not receiving the specific care activity at the intervals listed on the schedule.

During an interview with a direct care staff, they said there was a time that for a month the

resident did not have the specific care activity completed.

Missing this specific care activity put the resident at risk of infection and discomfort, as well as affected their overall well-being.

Sources: Observations, resident clinical record, and staff interviews.

[000753]

The licensee has failed to ensure that the care set out in a resident's plan of care, was provided to the resident as specified in the plan.

Rationale and Summary
A Complaint was received by the Director regarding the care and services of a resident.

The resident's care plan included three specific devices. During an observation of the resident, these devices were not seen in place, and activated. Device one was previously reported by a direct care staff to have been broken.

A different direct care staff came to the room during the observation and reported that device two must have been broken because it did not activate as expected and reported that device three was not provided to the resident appropriately at the time of the observation.

The direct care staff assisted the resident, then immediately replaced device two, and device one was seen on the resident during a secondary observation.

There was a risk for the resident's safety, when the devices indicated in their plan of care were not provided appropriately.

Sources: Staff interviews, the resident's care plan, observations of the resident.

[000752]

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that staff documented resident care provision set out in their plan of care.

Rationale and Summary
During an inspection, Inspector #000753 was provided a completed record of a resident for a specific care activity, by the Assistant Director of Care (ADOC). The record indicated that this care activity was missed on specific dates, with no record of refusals. When asked why there was no documentation at times the resident was to receive the care activity, the ADOC said that staff did not record the refusals, but they should have done so.

A review of the home's Clinical Documentation and Resident Assessment Policy stated that all disciplines providing care to the resident would chart on the medical record in accordance with their professional standards and corporate procedures. All treatments would be documented on the treatment record with the time and the initials or signature of the person completing the treatment.

By not documenting care, the licensee did not have the information about missed care for the resident in order to put in strategies to resolve the cause(s) of the missed care activity.

Sources: Resident clinical record, peopleCare Documentation and Resident Assessment Policy Reference, and staff interviews.

[000753]

WRITTEN NOTIFICATION: Communication and Response System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that a resident-staff communication and response system was easily seen, and accessible by residents at all times.

Rationale and Summary
A Critical Incident report submitted by the home, indicated that the home received a complaint regarding the care of a resident.

During an interview with a registered nursing staff, they indicated that the resident's call bell was out of reach from the resident at the time of the incident.

The home's Call Bell Response Policy stated that all call bells would be responded to promptly, and that all staff would place call bells within the reach of the resident when in bed or in the bathroom or if seated, in resident room and unable to move without assistance.

By not having access to their call bell when the resident needed help, the resident's health and wellbeing was at risk and the resident was in distress.

Sources: Critical Incident report, Call Bell Response Policy Reference, and staff interviews.

[000753]

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as

determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

Rationale and Summary
During an inspection, Inspector #000753 was provided a completed bathing record of a resident by the Assistant Director of Care (ADOC). The record indicated that the resident was getting on average one bath per week. There were many missed baths, with no record of refusals.

A direct care staff said during interview, that the resident had been getting only one bath a week, and not two as scheduled.

By not providing regular baths to the resident as scheduled, the home put the resident at risk of infection, feeling uncomfortable and impacting their mood, behaviour, and overall health and well-being.

Sources: Resident clinical record and staff interviews.

[000753]

WRITTEN NOTIFICATION: Foot Care and Nail Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee failed to ensure that a resident received fingernail care.

Rationale and Summary
During an interview with the resident, inspector #000753 observed that the resident's fingernails were dirty.

When the assigned direct care staff to the resident was asked about the fingernails, they said they washed the resident's hands with a towel but did not have cleaning supplies to remove the residue from under the nails. They also said that the home had run out of supplies to clean the fingernails and that management was aware.

The Assistant Director of Care (ADOC) said during interview, that there were no issues with supplies in the home that they were aware of.

There was risk of the resident transferring disease-causing micro-organisms to themselves from their dirty fingernails.

Sources: Observation and staff interviews

[000753]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that a resident, who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary
A Review of a resident's progress notes indicated a concern that the resident was served a meal without assistance.

During an interview with the homes Assistant Directors of Care (ADOCs), the ADOC said they investigated the incident, and that staff member acknowledged that they did not set up the meal properly for the resident. They intended to come back and assist the resident, but they forgot because an incident happened with another resident.

By not setting up the food in a way that was accessible for the resident, that meant the resident did not have a pleasurable meal, and made them upset.

Sources: Resident clinical record, and staff interviews.

[000753]

WRITTEN NOTIFICATION: Complaint Response

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

The licensee has failed to ensure that a response entailing what the licensee had done to resolve a complaint, was provided to a resident's Power of Attorney (POA), who made a complaint concerning the care of the resident.

Rationale and Summary
The home received a written complaint concerning the care of a resident.

In an interview with the Director of Care (DOC) they were unsure if a response had been provided to the complainant of their internal investigation results, and stated they were not able to find a record of a response. In interview with the POA who wrote the complaint, they informed that they were never provided with any response as to what happened.

There was a risk to the resident that their POA could not make informed decisions for the resident, when they were not provided a response on what was done to resolve their concerns for the resident.

Sources: Staff interviews, POA interview, complaint email sent to the home.

[000752]

WRITTEN NOTIFICATION: Medication Management

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that their written medication management system was implemented when a resident's medication order was not processed.

Rationale and Summary
A Critical Incident System (CIS) report received by the Director, indicated there was a medication incident involving a resident.

During an interview with the resident's physician they identified that they had sent a specific medication order, on a specific date for the resident. During a record review of the resident's physical chart and Point Click Care (PCC) this order was not found. The Director of Care (DOC)

printed out and provided a copy of the order along with a confirmation of receiving the order sent by a registered nursing staff. The DOC informed that during their internal investigation, they were never able to find any further record of this order or any confirmation it had been faxed to the pharmacy.

In an interview with the registered nursing staff member, they stated that they faxed the order to the unit nurse, and the unit nurse should have faxed it to the pharmacy. The home's Physician Order Policy stated that the Registered Nurse or Registered Practical Nurse would process physician's order immediately. The DOC explained in interview that when a registered nursing staff receives an order via email, they should print it out and fax it to the pharmacy.

Another registered nursing staff member identified in an interview that they had been working with the resident, when it came to their attention that the resident was not taking the specific medication, therefore they contacted the physician for an order. There was another order for the resident found in their physical chart, and in their Medication Administration Record (MAR).

The physician identified that the resident was not harmed by the delay in starting the specific medication. Although, there was a risk to the resident that the missed order could have gone unnoticed when it was not processed according to the homes policy and procedures.

Sources: Staff interviews, resident clinical records. Physicians Orders Policy.

[000752]

WRITTEN NOTIFICATION: Medication Incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident was documented.

Rationale and Summary
A Critical Incident System (CIS) report received by the Director, indicated there was a medication incident involving a resident.

During a record review it was identified that an order for a specific medication, was received on a specific date from a physician for a resident. The Director of Care (DOC) stated that the medication order for the resident, had not been processed as expected, which led to a delay in starting the medication. When an incident report was requested from the DOC, they stated that one was not completed for this incident, they advised that a medication incident report should have been completed.

There was a risk to the resident when the medication incident was not documented that actions may not have been taken or evaluated for the incident.

Sources: Staff interviews, Resident medication administration record, resident prescriber's order.

[000752]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

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

A) Provide training to all Personal Support Workers and Registered Nursing staff on a specific unit, regarding the expectations in the home for providing monitoring to residents during meals. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.

B) Conduct audits on all residents who are having meals in their rooms, on a specific unit, three times per week. A documented record must be maintained of these audits, including the date the audit was completed, who completed the audit, any concerns identified, and the corrective action taken because of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee failed to ensure that a resident was monitored in their room during meals.

Rationale and Summary
During interview with the home's Assistant Directors of Care (ADOCs), the ADOC said, the home investigated an incident and the staff involved acknowledged that they did not supervise the resident during meals and the staff was educated. The staff member said they did not know that the resident was supposed to be supervised. The ADOC said, staff were supposed to supervise residents when they have meals in their rooms.

There was a risk that the resident could not have been seen or helped in the event of a choking incident, when they were unsupervised in their room while eating a meal.

Sources: Written complaint, resident clinical record, and staff interviews.

[000753]

This order must be complied with by February 16, 2024

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.