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**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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# Original Public Report

**Report Issue Date:** April 10, 2024

**Inspection Number:** 2024-1462-0001

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** peopleCare Communities Inc.

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

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Samantha Perry (740) | Samantha Perry Digitally signed by Samantha Perry Date: 2024.04.10 15:10:28 -04'00' |

**Additional Inspector(s)**
Adriana Tarte (000751)

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 19, 20, 21, 2024

The following intake(s) were inspected:

- Intake: #00105764 - Complaint related to residents' rights;
- Intake: #00106476 - CIS #2980-000005-24, related to resident injury of unknown origin;
- Intake: #00107433 - Follow-up to Compliance Order (CO) #001 / #2023-1462-0006 related to O. Reg. 246/22 - s. 79 (1) 3. Dining and snack service. CDD February 16, 2024.

- Intake: #00108569 - Complaint related to allegations of staff to resident abuse;
- Intake: #00108792 - CIS #2980-000013-24, related to allegations of staff to resident abuse;
- Intake: #00108947 - CIS #2980-000015-24, related to an outbreak.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1462-0006 related to O. Reg. 246/22, s. 79 (1) 3. inspected by Samantha Perry (740)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

# 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. 3 (1) 6.**
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:
6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The licensee has failed to ensure a resident had the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

**Rationale and Summary**
A review of a resident's medical records documented the resident had a visitation restriction involving a visitor, and had had a discussion with the Executive Director (ED) during which the resident confirmed they wanted to see the visitor with no restrictions.

The resident said they would like the visitor to visit with no restrictions or monitoring.

The Executive Director (ED) confirmed they spoke with the resident, and, at that time, the resident wanted the visitor to visit with no restrictions or monitoring. The

ED stated they would remove the visitation restrictions and update the plan of care to reflect the resident's wishes.

A review of the resident's medical records showed that the visitation restrictions were removed.

The resident's right to communicate in confidence, receive visitors of their choice, and consult in private with any person without interference was not respected or promoted when the visitation restriction was implemented.

Sources: The resident's medical records, and interviews with the resident and ED.

**Date Remedy Implemented:** March 20, 2024. [000751]

## WRITTEN NOTIFICATION: Right to Quality Care and Self Determination

NC #002 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 a resident received the proper care consistent with their needs.

The Ministry of Long-Term Care (MLTC) received a complaint and two critical incident system (CIS) reports related to two incidents of staff to resident incompetent care.

A clinical record review for the resident documented several specific interventions staff were to implement with the resident during any interactions, including while they provided direct care.

Throughout the course of the inspection the inspector reviewed two video recordings capturing staff to resident incompetent care. At which time it was observed that staff were not implementing the interventions documented as part of the resident's plan of care. There were also within the two instances reviewed other instances where staff provided direct care to the resident in direct contradiction of the interventions documented.

The Director of Care (DOC) said they would expect staff to follow the resident's plan of care as documented, and when staff did not follow the plan of care and also provided direct care in contradiction of the plan of care, the staff were providing incompetent care. The incompetent care provided by the staff members put the resident at risk and impacted the resident's right to proper care consistent with their needs.

Sources: The resident's clinical records, the home's investigation and interviews with management. [740]

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

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, followed by the required report.

**Rationale and Summary**

A review of the home's records related to an outbreak documented the outbreak was declared on February 11, 2024, by the Middlesex-London Public Health Unit (MLPHU). The Director of the Ministry of Long-Term Care was informed on February 12, 2024.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) acknowledged the report to the Director was not reported immediately as per the legislation.

**Sources:** The home's records and interviews with the DOC and ADOC. [000751]