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

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: March 15, 2024
Inspection Number: 2024-1122-0001
Inspection Type: Complaint Critical Incident
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Meaford LTC, Meaford

Lead Inspector Tanya Murray (000735)	Inspector Digital Signature Tanya Murray Digitally signed by Tanya Murray Date: 2024.03.15 16:00:59 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26-29, and March 4-6, 2024.

The following intake(s) were inspected in this Critical Incident inspection:
- Intake #00103793 was related to responsive behaviours, and
- Intake #00105832 and intake #00107038 were related to infection prevention and management.

The following complaint was inspected:
- Intake #00108157 was related to care and support services, fall prevention and management, and skin and wound management.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Ontario Regulation 246 / 22, 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident; (mauvais traitements d'ordre physique).

Rationale and Summary
A resident hit another resident which resulted in injury.

Failure to protect the resident from abuse resulted in physical harm and injuries.

Sources: Clinical records, and staff interviews.
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WRITTEN NOTIFICATION: Care and Support Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee failed to ensure that a care conference is held within six week following the resident's admission.

Rationale and Summary
Two resident's did not have an admission care conference with the interdisciplinary team and family to discuss the plan of care for the resident within six weeks following their admission.

A resident had their admission care conference held approximately three months after their admission, and the other resident was approximately six months after admission.

Important resident information may not be included in the plan of care when the home does not complete the care conference within six weeks of their admission.

Sources: Clinical records, and staff interviews.
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