Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
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Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 17, 2023	
Inspection Number: 2023-1122-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Meaford LTC, Meaford	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24-28, 31, and August 1-2, 2023

The following intake(s) were inspected:

- Intake #00088569, related to allegations of staff to resident abuse
- Intake #00093371, related to falls prevention and management
- Intake #00089018, related to resident care concerns and complains process.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that when a resident's plan of care for falls prevention was revised because care set out was not effective, different approaches were considered in the revision of the plan of care.

Rationale and Summary

A resident was at risk for falls and had a history of falls.

In approximately a two-month period, the resident had multiple falls and two of these falls resulted in injuries.

Multiple post fall assessments completed in the above period documented that a post fall conference was to be held and documented with the goal to decrease risk of injuries.

There was no documentation that the post fall conferences were held. New strategies were not implemented in the resident's plan of care until the resident had a subsequent fall resulting in injury and following concerns expressed by their Substitute Decision Maker (SDM).

The Director of Care (DOC) said a post fall huddle to review falls and consider new falls prevention strategies should have been completed following the resident's multiple falls in the above period.

By not considering new approaches in the revision of the resident's plan of care, it may have contributed to the delay in the implementation of new falls prevention strategies.

Sources: a resident's clinical records, the home's Falls Prevention and Management Program policy, and interviews with the DOC and other staff. [758]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in a resident's plan of care related to one of the falls prevention interventions was based on the resident's assessment and their needs.

Rationale and Summary

A resident was at risk for falls and had multiple falls. The resident's care plan documented a specific intervention to be in place to minimize the risk for falls.

Multiple observations showed that this intervention was in place.

The physiotherapist, the home's Falls Lead, and the DOC said they were not aware of this intervention and did not recommend it. The home's Falls Lead, and the DOC said this intervention was not appropriate as it was not based on the resident's assessment and needs.

By implementing a fall prevention intervention without completing an assessment and considering the resident's needs, increased the resident's risk for falls and injuries.

Sources: observations of a resident's room, a resident's clinical records, and interviews with PSWs, an RPN, the home Falls Lead, the DOC, and the physiotherapist. [758]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

A resident was at risk for falls due to their condition and a history of falls. The resident's plan of care documented specific interventions to be implemented to prevent falls and minimize the risk of injuries from falls.

Multiple observations showed that these interventions were not in place as specified in the resident's plan of care.

The DOC said staff should follow falls prevention interventions as indicated in the resident's plan of care.

By not ensuring the resident's plan of care for falls prevention was followed, it increased the resident's risk of falls and injuries.

Sources: observations of a resident's fall prevention interventions, a resident's clinical records, and interviews with a PSW, RPNs, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident.

Rationale and Summary

The home's written policy to promote zero tolerance of abuse and neglect of residents documented that upon becoming aware of a potential or actual abuse of a resident, the Charge Nurse would assess for any injuries, and utilize the Nursing Checklist for Reporting Investigations of Alleged Abuse. The Checklist directed registered nursing staff to document a Head-to-toe assessment in the resident's chart, initiate monitoring for injuries, notify the physician and discuss the need for assessment and document the physician's response in the clinical record. The police should be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

A resident reported an allegation of abuse to two registered staff and the Manager on call.

The home's prevention of abuse policy was not followed when staff became aware of the allegation of abuse.

The DOC said staff should have followed the steps for investigating the alleged abuse as indicated in the home's prevention of abuse and neglect policy.

By not following the steps outlined in the home's policy when an allegation of abuse was brought forward, the resident was at risk of harm.

Sources: a critical incident report, a resident's clinical records, the home's investigation records, the home's Abuse or Suspected Abuse/Neglect of a Resident policy, and interviews with an RPN, an RN, the Office Manager, the DOC and other staff.

[758]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an incident of suspected abuse of a resident was immediately reported to the Director.

Rationale and Summary

A resident reported an incident of alleged abuse to two registered staff. An RN suspected abuse and reported immediately to the Manager on call.

The incident was not reported to the Director until two days later.

The home’s failure to immediately report the suspicion of abuse to the Director, may have delayed the Director’s ability to respond to the incident in a timely manner.

Sources: a critical incident report, the home’s investigative records, and interviews with an RPN, RN, the Office Manager, and the DOC.

[758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that interventions implemented for a resident under the Falls Prevention and Management program, and actions taken for a resident under the Nursing Program, were documented.

Rationale and Summary

A. A resident was at risk for falls and had a history of falls.

The resident's plan of care documented specific falls prevention strategies to be checked at identified time intervals. These interventions were to be documented in the resident's Point of Care (POC).

In approximately a three-month period, there was missing documentation of these checks on multiple dates and times.

The DOC said that the interventions should have been documented in the resident's POC, as required.

Gaps in the documentation of the falls prevention interventions made it difficult to evaluate the effectiveness of these interventions.

Sources: a resident's clinical records, and interviews with the DOC. [758]

B. A resident reported pain to registered staff over three to four days.

There was no documentation of any assessments, interventions provided and the resident's responses to these interventions.

The DOC said staff should have documented the assessments and interventions provided to the resident.

By not documenting the actions taken in relation to a resident's pain and the resident's response, staff may not be aware of the interventions provided and it may have contributed to the delay in implementing appropriate actions.

Sources: a resident's clinical records, the home's investigative records, and interviews with an RN, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee failed to ensure that a response, to include an explanation of what was done to solve the complaint was provided to the person who made a complaint related to a resident's care.

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Rationale and Summary

A complaint related to a resident's care was received by the Executive Director.

The complainant was directed to follow up with the home's DOC and the physiotherapist.

The concerns were not resolved after discussions with the DOC and the physiotherapist and no follow up with the complainant was completed after that time.

By not providing a response to the complainant regarding their concerns, they were not able to understand what the home did to solve their concerns and were unsatisfied with the outcome.

Sources: the home's complaint records, and interviews with the ED, the DOC and the physiotherapist.
[758]