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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 25, 2024

Inspection Number: 2024-1122-0005

Inspection Type:
Complaint
Critical Incident

Licensee: peopleCare Communities Inc.

Long Term Care Home and City: peopleCare Meaford LTC, Meaford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8-11, 15, 17, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00123414 was related to responsive behaviours.
- Intake #00123830/CI#3062-000027-24 was related to a complaint; and
- Intake #00127060/CI#3062-000031-24 was related to infection prevention and control.

The following intake(s) was completed in this complaint inspection:

- Intake #00123894 was related to medication management and prevention of abuse and neglect.

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Rationale
A resident struck a co-resident causing an injury.

The progress notes for the resident, the alleged abuser, indicated that they had responsive behaviours on several occasions. On numerous dates, the resident was agitated, attempted to push staff away, exhibited responsive behaviours when giving medications, and had altercations with co-residents. The responsive behaviours were not included in the resident's care plan, nor had triggers or

interventions been identified.

A Personal Support Worker (PSW) confirmed that resident's responsive behaviours included wandering, exit seeking, aggressiveness, agitation, verbally abusive to the other residents, and sometimes staff. The PSW confirmed that the responsive behaviours were random, and did not happen at a specific time of the day.

A Registered Practical Nurse (RPN) confirmed that the care plan was not up to date, and did not include any other responsive behaviours besides resisting cares. The RPN confirmed that the resident could be verbally aggressive.

Failure to include responsive behaviours and interventions on the resident's care plan could jeopardize the safety of the staff and other residents.

Sources: Resident's clinical records, and interviews with PSW and RPN.