Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2015	2015_299559_0015	T-1984-15	Complaint

Licensee/Titulaire de permis

HILLCREST VILLAGE INC.
255 RUSSELL STREET MIDLAND ON L4R 5L6

Long-Term Care Home/Foyer de soins de longue durée

HILLCREST VILLAGE CARE CENTRE
255 RUSSELL STREET MIDLAND ON L4R 5L6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANN HENDERSON (559)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 10, 13 and 14 July, 2015.

During the course of the inspection, the inspector(s) spoke with administrator, assistant administrator, director of resident care (DRC), assistant co-director of care, resident care facilitator (RCF), registered practical nurse (RPN), personal support worker (PSW), resident and family members.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Record review and an interview with the power of attorney(POA)for care for a resident revealed the resident had an identified medical condition that required a surgical intervention. The resident is currently being seen by a skin and wound specialist who has provided treatment recommendations.

On an identified date the POA observed the treatment intervention had been applied incorrectly to the resident's identified area. The lamb's wool had been wrapped tightly and when it was removed it was noted the lamb's wool had left deep indentation marks that were "as thick as a power cord".

An interview with RCF #107 revealed during the investigation of the incident the nurse who had been working on the specific shift, could not remember if he/she had applied the treatment. The home implemented a daily charting form for the registered staff to sign when the treatment intervention was completed each day.

Review of the daily charting form registered staff were directed to sign to indicate the treatment intervention was applied correctly over a four month period, revealed 30 missing signatures and the daily charting form for the current month for staff to sign had not been posted. An interview with RPN #112 revealed the daily charting form could not be located for the current month and as a result registered staff had not signed that the treatment had been applied correctly as directed.

The POA revealed this was not the first time the treatment was applied incorrectly; on a previous occasion an RPN had completed the treatment incorrectly and the POA had to intervene and show the nurse.

An interview with RPN #104 revealed on an identified date, a physician order was received that indicated the resident was not to self propel the wheelchair. During the inspection, the resident was observed to be foot propelling in the foyer and hallway. Interviews with PSW #102 revealed when the resident is up in the wheelchair the resident is to be portered in the wheelchair. PSW #103 revealed the resident is to have his/her foot on the foot rest, however, the resident continues to self-propel in the wheelchair.
During the inspection, the DRC revealed a box footrest was applied to the resident's wheel chair which did not enable the resident to foot propel.

A review of policy Skin Care, Wound Prevention and Wound Management Program revised January 2014, directs staff to provide skin care measures to promote healing and

prevent deterioration and pressure.

The RCF confirmed staff failed to ensure the physician's order was followed and did not provide skin and wound care to the resident as per the plan of care.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when the home receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

On an identified date, the DRC was made aware of a written complaint from the POA for an identified resident. The written complaint concerned the incorrect application of the treatment intervention for the identified resident.

The DRC confirmed the written complaint and response concerning the care of a resident was not forwarded to the Director. [s. 22. (1)]

Issued on this 13th day of August, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.