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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2018	2018_668543_0015	012151-18	Resident Quality Inspection

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

TIFFANY BOUCHER (543), MICHELLE BERARDI (679), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 25-29, 2018 and July 3-5, 2018

Additional Intakes inspected during this Resident Quality Inspection (RQI) included:

Four intakes related to falls;

Three intakes related to abuse;

One intake related nutrition and

Two complaint intakes related to resident care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, Activity Program Coordinator, family members and residents.

Inspectors also conducted daily tours of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, procedures, programs, personnel files, observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **3 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Director in 2017, regarding an incident where resident #010 sustained a fall that resulted in an injury. The CI report identified that the resident was left unattended which was contrary to their care plan.

Inspector #638 reviewed the internal investigation records and identified that PSW #102 was providing care to resident #010 and left the resident unattended. Upon returning to the room, PSW #102 stated they witnessed the resident fall.

Inspector #638 reviewed resident #010's care plan in effect at the time of the fall that occurred in 2017, and identified that the resident required two staff present for specific interventions related to care.

Inspector #638 reviewed a document where PSW #102 acknowledged they failed to follow the resident's care plan, on many accounts. The document identified that the PSW failed to ensure the specific interventions were implemented while providing care, as per the resident's care plan.

In an interview with Inspector #638, PSW #101 indicated that their role in fall prevention included ensuring that the interventions laid out within the care plan were implemented. The PSW stated that staff referred to the resident's care plan for specific interventions to manage their fall risk. In an interview with the Inspector, PSW #106 indicated that they were always expected to ensure that the care planned interventions were implemented.

During an interview with Inspector #638, RPN #103 indicated that staff refer to the communication notes, report binder and residents' care plan for specific fall interventions. The RPN stated that staff should follow the resident's specific care plan for resident care interventions.

In an interview with Inspector #638, the DOC indicated that staff referred to a resident's care plan, kardex and care sheets for resident specific care interventions. The Inspector reviewed resident #010's fall incident that occurred in 2017, with the DOC. The DOC indicated that PSW #102 was providing care to the resident on their own and left the resident unattended resulting in the resident falling. The DOC indicated that the PSW did not follow the resident's care plan and the PSW should have had another staff present for specific care. [s. 6. (7)]

2. A CI report was submitted to the Director for an incident of improper/incompetent care resulting in harm or risk of harm. The CI report outlined that resident #009 was served

the improper diet type, which resulted in the resident choking.

Inspector #679 reviewed the electronic progress notes which identified that RPN #107 entered the dining room and found resident #009 coughing. RPN #107 observed that resident #009 had been provided with the wrong texture of food on their plate. The note identified that resident #009 was supposed to have a specific diet texture.

A review of the electronic care plan in place at the time of the incident identified that the resident was to receive a specific diet texture. A review of the dietary sheets, also identified the resident was to receive a specific diet texture

In an interview with PSW #111, they identified that they had told the dietary aid the resident's table, the residents name and the selected meal choice. The PSW received the meal from the dietary aid and delivered it to resident #009. PSW #111 stated that both the dietary aid and the PSW were supposed to check the reisdent's diet type before serving the meal. PSW #111 acknowledged that they didn't check the diet list as they were busy serving the meal.

In an interview with Dietary Aid #116 they identified that resident #009 had a specific diet texture, and that they had only reviewed one part of the diet on the diet list. Dietary Aid #116 identified that they had given resident #009 the wrong diet texture.

In an interview with RPN #107 they identified that they had entered the dining room to find resident #009 coughing. RPN #107 identified that they had observed that the resident had received the incorrect diet and removed the plate. RPN #107 stated that when they spoke with the PSW, they identified the PSW didn't complete their check of the diet list prior to serving the meal.

In an interview with Inspector #679, the DOC identified that the dietary aid was suppposed to reference the diet list when serving meals. The DOC identified that resident #009 was on a specific diet texture, and that dietary aid #116 had only read a portion of the diet list. The DOC identified that the resident had not received their diet as outlined in the plan of care. [s. 6. (7)]

3. A CI report was submitted to the Director on a specific date in 2018, related to alleged resident neglect. According to the CI report, resident #011's family member was upset that PSW #108 had refused to provide specific care to the resident.

Inspector #543 reviewed the home's internal investigation notes, which indicated that PSW #108 had failed to follow resident #011's care plan related to the resident's specific care needs, which was in direct violation of the home's policy and procedures.

Inspector #543 reviewed the resident's care plan implemented at the time of the incident, which identified that resident #011 would receive care as they requested.

Inspector #679 interviewed PSW #120 who verified that resident #011 should receive care are per their request, as it was indicated in their care plan.

Inspector #543 interviewed RN #110 who indicated that resident #011's family had brought forward concerns related to care. RN #110 verified that at that time, resident #011's care plan had indicated that when the resident requested care it should have been provided as indicated in their care plan.

Inspector #638 interviewed the DOC who verified that resident #001 should have received care, as indicated in the interventions identified in the plan of care. [s. 6. (7)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #543 reviewed the home's Anti-Abuse and Neglect Policy, with a revision date of May 16, 2018, which defined sexual abuse as non-consensual touching, behaviour or remarks of sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member. This policy indicated that all employees are responsible for preventing and reporting acts of abuse or neglect. If staff witnessed any action related to abuse and/or neglect, they must immediately report the incident to a member of management. The policy stated that the licensee will immediately report to the Director of the Ministry of Health and Long-Term Care, every suspected, alleged, witnessed or confirmed incident of abuse and/or neglect.

A review of the policy entitled "Critical Incidents (CIS) and Mandatory Reporting Policy" last revised October 18, 2016, identified that the facility would ensure that the Director was informed immediately, in as much detail as possible, of the circumstances of any of the following incidents in the home: improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

a) A CI report was submitted to the Director for an incident of improper/incompetent treatment which resulted in harm or risk of harm to the resident. The CI report outlined that the incident occurred on a specific date in 2018, however was not reported until a day later.

Inspector #679 reviewed the electronic progress note dated a specific date in 2018, in which RPN #107 identified that they had entered the dining room to find resident #009 coughing. RPN #107 identified that resident #009 received the incorrect diet texture. The progress note identified that RPN notified the RN and the Director of Care.

In an interview with the DOC they identified that they could not recall when they were made aware of the incident. The DOC identified that they were likely notified via email of the incident. The DOC identified that the nurse managers are aware of the requirements for reporting and can call the Ministry's after-hours line. The DOC acknowledged that the CIS report was submitted late.

b) A CI report was submitted to the Director on a specific date in 2017, related to a specific form of alleged abuse.

Inspector #543 reviewed resident #005's most recent care plan, which identified that the resident had a history of being inappropriate in nature at times, and a history of specific inappropriateness towards co-resident.

Inspector #638 interviewed the DOC who verified that the incident that occurred on a specific date in 2017, should have been immediately reported to the Director. [s. 24.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, the symptoms indicating the presence of infection in residents, were recorded and that immediate action was taken as required.

Resident #005 and resident #006 were both identified as having an infection through their Minimum Data Set (MDS) assessment completed on specific dates in 2018.

a) Inspector #543 reviewed resident #005's health care records and identified a progress note, which stated the resident had a specific infection. The Inspector was unable to identify any notation regarding the resident's symptoms indicating the presence of infection.

b) Inspector #543 reviewed resident #006's health care records and identified in their progress notes that the resident had a specific infection. The Inspector was unable to identify any documentation regarding the resident's symptoms of infection.

In an interview with Inspector #638, PSW #118 indicated that residents are monitored during all care giving periods and any changes were reported to registered staff who would follow up with, and assess the resident.

During an interview with Inspector #638, RN #117 indicated that once a resident was isolated for an infection, registered staff were required to monitor symptoms of infection each shift. These assessments were documented in the resident's progress notes on Point Click Care (PCC). The Inspector reviewed resident #005 and resident #006's health care records and progress notes with the RN, who stated they were unable to identify any documentation regarding these resident's symptoms of infection during that period.

In an interview with Inspector #638, the DOC indicated that a resident would be isolated once they demonstrated two symptoms of infection. The DOC indicated that registered staff were required to monitor and document resident symptoms during each shift and the assessment included (but was not limited to); vital signs, specific symptoms (ie. productive cough), chest and lung assessment and how the resident is generally feeling. The DOC stated that the assessment should be documented in the progress notes on PCC. The Inspector reviewed the residents' progress notes with the DOC, who verified that registered staff should have documented on the residents' symptoms of infection on each shift. [s. 229. (5) (b)]

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Issued on this 12th day of July, 2018

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

Original report signed by the inspector.