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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 08, 2019	2019_616722_0001 (A1)	017319-18, 018509-18, 025020-18, 025551-18, 027919-18, 032095-18, 033783-18, 002446-19, 004258-19	Critical Incident System

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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There were no revisions to this public report. This amendment cover sheet was generated due to minor revisions to the Licensee Report.

Issued on this 8 th day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 25-28, and March 1, 2018

The following critical incidents were inspected during this inspection:

- Six critical incidents related to falls where the resident sustained an injury;

- Two critical incidents related to resident-to-resident abuse; and

- One critical incident related to staff-to-resident neglect and abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and resident family members.

The inspectors made observations of residents and resident home areas; reviewed electronic and hard copy clinical health records; and reviewed administrative records, including relevant policies, investigation notes, and training documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
0 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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report was submitted to the Director on a specified date for an allegation of staff-to-resident abuse and neglect. The CI report indicated that PSW #113 witnessed PSW #114 interacting in a specified manner towards resident #007 on an earlier specified date.

Inspector #736 reviewed the internal investigation package provided by the home. The Inspector reviewed a specific record made by the resident care facilitator (RCF), RN #108, in which PSW #113 indicated that they witnessed specified actions by PSW #114 toward resident #007. The record also documented that PSW #113 indicated that they were aware of the reporting requirement for suspected resident abuse and how they were to report the concern.

In an interview with Inspector #736, PSW #113 indicated that they had witnessed a specified incident involving PSW #114 towards resident #007 on a specified date. PSW #113 further indicated that they did not immediately report this incident as it was during a specified time of day; however, they reported the incident on a later date to DOC #102.

Inspector #736 reviewed the home's “Anti-Abuse & Neglect Policy”, last reviewed on May 18, 2018, which indicated that all employees, if they witnessed any action related to abuse and/or neglect in the workplace, were to immediately report the incident to a member of Management.

In an interview with Inspector #736, DOC #102 indicated that the incident involving PSW #114 and resident #007 took place on an earlier specified date, and that they only became aware of the incident during an investigation interview that took place on a later specified date. The DOC confirmed to the Inspector that the home’s policy to promote zero tolerance of abuse and neglect of residents was not complied with.

The licensee failed to ensure that the licensee's written policy that promoted zero tolerance of abuse and neglect of residents was complied with, when a staff member failed to immediately report an incident of suspected abuse or neglect to a member of Management. [s. 20. (1)]

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 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: 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.

A CI report was submitted to the Director on a specified date, related to an incident of abuse involving resident #004, toward a co-resident, that occurred on an earlier specified date.

PSW #106 was interviewed by Inspector #722, and confirmed that they had witnessed the incident on a specified date, where resident #004 was observed in

a resident home area, interacting with an identified co-resident in a specified manner. PSW #106 indicated that they separated the residents involved, and immediately reported the incident to the registered staff on duty. PSW #106 was unable to recall which registered staff member to whom they reported the incident.

Inspector #722 interviewed RPN #104, who indicated that they were working in the home on the specified date, and were on duty in the resident home area where the incident occurred. RPN #104 confirmed that they were notified of the incident soon after it was witnessed by PSW #106. RPN #104 indicated that after separating the residents and notifying the resident's substitute decision makers (SDMs), they notified RN #117 of the incident. RPN #104 indicated that RN #117 informed them that the licensee's internal CI report had to be completed. RPN #104 indicated that they completed the home's internal CI report on the same day the incident occurred, and confirmed that they did not call the Ministry of Health and Long Term Care (MOHLTC) after-hours pager.

RN #117 was interviewed by Inspector #722, and confirmed that they were working on the specified date that the incident occurred, as the RCF on duty in the resident home area. RN #117 did not have any recollection of the event, and did not recall being notified by RPN #104 of the incident. RN #117 did not recall notifying the MOHLTC via the after-hours pager, and indicated that if they had contacted the after-hours pager, that they would have documented the date, time, and confirmation number from the call. RN #117 also confirmed that they did not complete and submit to the Director the CI report for this incident.

RN #117 confirmed during the interview with Inspector #722 that the expectation is that all incidents of suspected, witnessed, or alleged abuse should be reported immediately, and that the MOHLTC after-hours pager should be contacted when such incidents occur on weekends and after usual business hours.

RN #103 was interviewed by Inspector #722, and indicated that they completed and submitted the CI report to the Director on a specified date, five days after the incident occurred. RN #103 explained that the incident occurred outside of business hours, and that the management team only became aware of the incident when they met on a specified date, five days after the incident occurred. RN #103 indicated that they submitted the CI report to the Director immediately upon becoming aware of the incident, and confirmed that the incident should have initially been reported to the MOHLTC through the after-hours pager.

Inspector #722 reviewed the licensee's "Resident Anti-Abuse and Neglect Policy", last reviewed on May 18, 2018, related to reporting requirements, which indicated the following:
- All employees are responsible for preventing and reporting acts of abuse and/or neglect.
- If you witness any action related to abuse and/or neglect in the workplace, you must immediately report the incident to a member of Management.
- Hillcrest Village Care Centre will immediately report to the Director of the Ministry of Health and Long Term Care, every suspected, alleged, witnessed or confirmed incident of abuse or neglect regardless of who did the abusing, or caused the neglect.

Inspector #722 interviewed the DOC, who indicated that the RCF on duty was considered part of the home's management team. The DOC explained that because the incident occurred and was reported to the RCF (RN #117) outside of regular business hours, that the RCF on duty should have contacted the MOHLTC after-hours pager to report the incident. The DOC indicated that the incident should have been reported immediately on the specified date, by the RCF on duty, via the MOHLTC after-hours pager.

The licensee failed to ensure that an incident of abuse by resident #004 towards a co-resident, that occurred on a specified date, was immediately reported to the Director, when there was no call to the MOHLTC after-hours pager on the day the incident occurred, and the critical incident report was submitted to the director five days after the incident occurred. [s. 24. (1)]

Issued on this 8 th day of March, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by COREY GREEN (722) - (A1)
Inspection No. / No de l'inspection :	2019_616722_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017319-18, 018509-18, 025020-18, 025551-18, 027919-18, 032095-18, 033783-18, 002446-19, 004258-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 08, 2019(A1)
Licensee / Titulaire de permis :	Hillcrest Village Inc. 255 Russell Street, MIDLAND, ON, L4R-5L6
LTC Home / Foyer de SLD :	Hillcrest Village Care Centre 255 Russell Street, MIDLAND, ON, L4R-5L6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johnathon Ens

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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To Hillcrest Village Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8 th day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by COREY GREEN (722) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Sudbury Service Area Office