Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2019	2019_655679_0017	004582-19, 010215-19, 011167-19	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

MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 8 - 12, 2019.

The following Critical Incident System (CIS) intakes were inspected upon during this inspection:

- Three intakes related to resident falls.

A Complaint Inspection (#2019_655679_0016) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Resident Care Facilitators (RCFs), Maintenance Supervisor, Physiotherapist, Restorative Therapy Coordinator, Restorative Nurse, Program Coordinator, Receptionists, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Cooks, Dietary Aides, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's plan of care set out clear direction to staff and others who provide direct care to the resident.

A Critical Incident (CI) report was submitted to the Director for the fall of resident #003. The CI report identified that resident #003 was found on the floor with injury.

Inspector #679 reviewed resident #003's electronic care plan and identified specific fall prevention interventions, under a specified focus. The Inspector also identified an intervention under the same focus which identified that the resident had refused the specified fall prevention interventions.

Inspector #679 conducted observations of resident #003 and identified that the specified fall prevention interventions were in place.

In an interview with PSW #104, they identified that resident #003 was at risk for falls, and that they had interventions in place to manage their risk for falls. PSW #104 identified that resident #003 had refused specified fall prevention interventions in the past; however, they were currently complaint with the interventions.

In an interview with Resident Care Facilitator (RCF) #119, they identified that a resident care plan would be updated whenever a resident status changed, and with the Minimum Data Set (MDS) assessment. Together, Inspector #679 and RCF #119 reviewed the electronic care plan. RCF #119 identified that the intervention regarding the residents' refusal of the specified fall prevention interventions should have been removed from the care plan.

In an interview with the Assistant Director of Care (ADOC), they identified that resident care plans were updated upon admission, quarterly and with any significant change to the resident's health status. Together, Inspector #679 and the ADOC reviewed resident #003's electronic care plan. The ADOC identified that the intervention identifying that the resident was refusing the specified fall prevention interventions should have been removed from the care plan. [s. 6. (1) (c)]

Issued on this 15th day of July, 2019

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

Original report signed by the inspector.