Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Dec 10, 2020	2020_828744_0005	021433-20	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

STEVEN NACCARATO (744)

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): November 30 and December 1 to 3, 2020.

The following intake was inspected during this Critical Incident System (CIS) inspection:
-One intake regarding improper care of a resident resulting in hospitalization.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Facilitators (RCF), Restorative Therapy Services Coordinator, Restorative Care Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, internal investigation notes, as well as specific licensee policies, procedures, and programs.

This inspection was also attended by Inspector Jennifer Brown (#647).

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)**
- **2 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. (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 specific to a mattress cover, was provided to a resident as specified in their plan.

There was no mattress cover on the resident's mattress as indicated in their plan of care.

The RN indicated that the mattress cover had been removed from the resident's mattress for days and it was needed to be in place because the resident was at risk for a wound.

Sources: Inspector observations; resident's electronic plan of care; and interviews with the RN and other staff members.

2. The licensee has failed to ensure that the care set out in the plan of care specific to footwear, was provided to the resident as specified in their plan.

The resident was not wearing the footwear they required, as indicated in their plan of care.

The RPN indicated that the footwear was needed to be on the resident's feet to avoid wounds.

Sources: Inspector observations; resident's electronic plan of care; and interviews with the RPN and other staff members.

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited a wound, was reassessed at least weekly by a member of the registered nursing staff.

There was a missing wound assessment for a resident.

The RN indicated that an appropriate weekly wound assessment was not completed for the resident.

Sources: Resident's electronic wound assessments; and interviews with the RN and other staff members. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that a specific mattress cover required for a resident to relieve pressure and promote healing, was readily available at the home.

There was no specific mattress cover in place for a resident as indicated in their plan of care.

The restorative care nurse indicated that the home did not have the specific mattress cover available for residents who needed a replacement.

Sources: Inspector's observations; and interviews with the restorative care nurse and other staff members. [s. 50. (2) (c)]

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 a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff; and to ensure that the equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

Issued on this 11th day of December, 2020

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

Original report signed by the inspector.