Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
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Original Public Report

Report Issue Date: November 7, 2024.
Inspection Number: 2024-1313-0002
Inspection Type: Critical Incident
Licensee: Hillcrest Village Inc.
Long Term Care Home and City: Hillcrest Village Care Centre, Midland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4- 7, 2024.

The following intake(s) were inspected:

- Two intakes related to allegations of improper resident care;
- One intake related to allegations of resident to resident physical abuse; and,
- Three intakes related to disease outbreaks.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that, as part of the Infection Prevention and Control (IPAC) Standards, signage was posted at the entrance to the resident's room that indicated the enhanced IPAC measures in place at the time. The signage was posted during the inspection.

Sources: Inspector observations; licensee policy; interview with a Resident Support Aide (RSA), and the IPAC Lead.

Date Remedy Implemented: November 6, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
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.

The licensee has failed to ensure that the care set out in the dietary care plan of a resident was provided to the resident.

Sources: A Critical Incident (CI) report; review of a resident's clinical records and the home's internal investigation; interview with a Personal Support Worker (PSW) and the Director of Care (DOC).

WRITTEN NOTIFICATION: Outbreak Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that when there was a disease outbreak reported through the After Hours (AH) line, that the written report was summitted to the Director the next business day.

Sources: CI report; and, interview with the DOC.