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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 24, 2016 | 2016_326569_0009 | 018322-15 | Critical Incident System |

## Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

## Long-Term Care Home/Foyer de soins de longue durée

peopleCare Hilltop Manor Cambridge
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

DONNA TIERNEY (569)

## 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): April 21 and 22, 2016.**

**The following CI's were inspected concurrently within this inspection:**
**Critical incident log #018322-15 / CI 2606-000011-15 related to staff to resident abuse;**
**Critical incident log #028877-15 / CI 2606-000019-15 related to staff to resident abuse;**
**Critical incident log #031911-15 / CI 2606-000021-15 related to staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Executive Director of Nursing, VP of Clinical Services, Director of Resident Care, one Registered Nurse, five Personal Support Workers, several residents, and a detective with the Elder Abuse Response Team of the Waterloo Regional Police Service.**

**The Inspector also conducted a tour of several home areas and made observations of residents, care, and staff to resident interactions. Relevant policies and procedures, the home's internal investigation reports, as well as clinical records and plans of care for identified residents were reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged or suspected incident.

Record review of the home's internal investigation notes revealed that on a specified date in 2015, an initial concern was brought forward to the home regarding an allegation of staff to resident abuse.

Review of the Critical Incident System showed that a report to the Director was submitted 12 days after the initial date of the alleged incident.

The Executive Director of Nursing was interviewed on April 22, 2016. She agreed there was a time lapse of 12 days from initially learning of the alleged incident to when it was reported and had failed to make a written report to the Director within 10 days of becoming aware of the alleged incident. [s. 104. (2)]

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**Issued on this 24th day of June, 2016**

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

**Original report signed by the inspector.**