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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 17, 2017	2017_566669_0014	026341-16, 030422-16, 030426-16, 034730-16, 010631-17	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

ANDREA DIMENNA (669), CAROLEE MILLINER (144), SHERRI COOK (633)

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): June 19, 20, 21, 22 and 23, 2017.

The following critical incidents were completed with this inspection:

#2606-000025-16/026341-16, related to alleged abuse
#2606-000029-16/030422-16, related to alleged abuse
#2606-000030-16/030426-16, related to alleged abuse
#2606-000039-16/034730-16, related to alleged abuse
#2606-000012-17/010631-17, related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with 15+ residents, Executive Director, Executive Director of Nursing Care, two Directors of Resident Care, Vice President of Clinical Services, Assistant Executive Director, Director of Recreation, Physiotherapist Assistant, two Registered Nurses (RNs), nine Registered Practical Nurses (RPNs), two Resident Care Aides (RCAs), and nine Personal Support Workers (PSWs).

During the course of the inspection, the Inspectors made observations of residents, activities, interactions with staff, and provisions of care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care and outcomes of that care that were set out in the plan of care were documented.

A Critical Incident Report related to an alleged staff to resident incident was submitted to the Ministry of Health and Long-Term Care on a specific date by Executive Director of Nursing Care (EDNC) and Director of Resident Care.

Record review of the plan of care for the resident and in interviews with PSWs and a RN, they stated that the resident had care interventions implemented earlier this year.

The resident required total assistance from staff for specific provisions of daily care as well as a specific provision of care that was required to be provided every two hours.

A record review of completed tasks for the resident stated that a specific provision of care was required every two hours.

The home's investigation records included that on a specific date:
- At 0630 hours, the resident was checked and stated being "ok".
- At 0730 hours, a PSW provided morning care, including specific care interventions.
- At 0830 hours, a PSW asked the resident to get up and the resident declined.
- At 0945 hours, a PSW checked on the resident.
- "Before lunch," a PSW "put the resident back to bed."

The electronic tasks used by PSWs to document resident care and outcomes of that care were reviewed for the resident on a specific date and did not include documentation for a specific type of daily care. In addition, another care intervention required every two hours was not documented on a specific date between the hours of 0100 and 0900 hours and at 2300 hours.

The PSW Job Description (Reference No. 010040.40) stated that PSWs were to document resident care activities in accordance with the home's policy and software. The Multidisciplinary Documentation Policy (Reference No. 00960.00) stated that PSWs' entries in the residents' health records were to be in chronological order in the software's electronic tasks and closest to the time of the event as possible.

In interviews with a PSW, Registered Practical Nurse and EDNC, they stated that the

expectation was that PSWs documented resident care in the electronic tasks at the time care was provided to the resident. EDNC agreed that the resident's care and outcomes of that care should have been documented for the specific date, and were not.

The licensee has failed to ensure that, on a specific date, the provision of care and the outcomes of that care that were set out in the plan of care for the resident were documented.

The severity was determined to be a level one as there was minimum risk, and the scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on: May 1, 2017, in a Resident Quality Inspection (RQI) as a Compliance Order (CO) with an upcoming compliance date; January 25, 2017, in a Complaint Inspection as a CO that was complied on June 9, 2017; May 3, 2016, in a RQI as a Voluntary Plan of Correction (VPC); March 16, 2015, in a RQI as a VPC; February 3, 2015, in a Critical Incident System Inspection as a CO that was complied on March 30, 2015. [s. 6. (9)]

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 provision of care and outcomes of that care that are set out in the plan of care are documented, to be implemented voluntarily.

Issued on this 18th day of July, 2017

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

Original report signed by the inspector.