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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_566669_0013	015275-16, 024835-16, 025581-16, 000349-17, 001014-17, 007043-17, 007075-17	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): June 19, 20, 21, 22 and 23, 2017.

The following complaints were completed with this inspection:

IL-46168-LO/log #024835-16, related to alleged neglect and improper care
IL-50199-LO/log #007043-17, related to alleged neglect and improper care
IL-44657-LO/log #015275-16, related to alleged neglect and improper care
IL-46405-LO/log #025581-16, related to alleged neglect and improper care.

The following critical incidents were completed with this inspection:
2606-000001-17/log #000349-17, related to alleged abuse and 001014-17, related to alleged illegal discharge
2606-000009-17/log #007075-17, related to neglect and improper care.

The finding in this inspection related to s. 6 (10) (b) regarding plan of care provides further evidence to support Compliance Order #001 issued on June 19, 2017, in inspection #2017_606563_0008 with a due date of July 28, 2017.

During the course of the inspection, the inspector(s) spoke with 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:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **2 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 O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident or the resident's substitute decision-

maker was notified when, (a) the resident’s personal aids or equipment were not in good working order or required repair.

During Complaint Inspections, it was identified that a resident was not using their usual piece of equipment and the resident's Power of Attorney (POA) was not informed of the situation.

The resident was observed on two occasions, using the same piece of equipment and appeared comfortable.

The resident's POA identified concern that the resident was not in their usual piece of equipment during a specified week. The POA said that they spoke with the Executive Director of Nursing Care (EDNC) and a PSW who both acknowledged that the piece of equipment that was being used by the resident at that time was not the resident's usual piece of equipment. The resident’s POA said that the resident’s piece of equipment was broken, and that the home gave the resident a spare piece of equipment, but the POA was never made aware of the switch or that the resident's usual piece of equipment needed repair.

A Service Log Book was reviewed and included a request that the resident’s piece of equipment required repair.

The resident's progress notes were reviewed, and there was no documentation related to notifying their POA about the broken piece of equipment.

A PSW reported that the resident’s usual piece of equipment had been gone since a specified date, and that, at that time, the resident was using a different piece of equipment and recalled that the resident verbalized to them that it was not their piece of equipment. The PSW said that the resident’s usual piece of equipment was fixed and returned to the resident recently. The PSW, a Resident Care Aide (RCA), and an RPN all acknowledged that the resident was currently using their usual piece of equipment.

The EDNC explained that the home’s process if a piece of equipment was broken included informing the resident’s POA. The EDNC acknowledged that on a specified date, the piece of equipment used by the resident was not the resident’s usual piece of equipment. The EDNC acknowledged that the resident’s POA should have been contacted to inform them that the resident’s piece of equipment needed repair and that the resident was using a loaner in the meantime.

The licensee has failed to ensure that the resident's substitute decision-maker was notified when the resident's piece of equipment required repair.

The severity of this issue was determined to be a level one as there was minimum risk, and the scope was a pattern during the course of this inspection. The home's compliance history was reviewed and showed no related non-compliance. [s. 38.]

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 or the resident's substitute decision-maker is notified when, (a) the resident's personal aids or equipment are not in good working order or require repair, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan was met; (b) the resident's care needs changed or care set out in the plan was no longer necessary; or (c) care set out in the plan had not been effective.

A Complaint was received by the Ministry of Health and Long-Term Care from the family of an identified resident, which alleged that the home neglected to diagnose and treat the

resident for a medical condition.

The following is further evidence to support Compliance Order #001 issued on June 19, 2017, from the Resident Quality Inspection (#2017_606563_0008) with a due date of July 28, 2017.

The home's policy related to signs and symptoms of a specified medical condition was reviewed and stated that the PSW would immediately report any of the listed signs and symptoms to the RN/RPN.

Point of Care (POC) Response History was reviewed and revealed that the resident showed three of the signs and symptoms of the identified medical condition listed in the home's aforementioned policy.

Progress notes were reviewed and included documentation by a staff member that noted two of the signs and symptoms of the identified medical condition. The resident’s progress notes were reviewed and did not include any documentation related to the physician being notified that the resident was exhibiting any of the three identified signs and symptoms.

A medical note, dated prior to the resident's admission to the home, was found in the resident’s physical chart and stated that the resident had the identified medical condition, and included recommendations for the management of the condition. Another document from the resident's chart was listed the resident's diagnoses, including the identified medical condition.

Test results from a specified date after the resident's admission to the home were reviewed from the resident’s physical chart and included a provisional diagnosis identified medical condition.

The resident’s electronic Medication Administration Record was reviewed and did not include any medications nor monitoring for the identified medical condition.

Progress notes stated that the resident was sent for further medical evaluation on a specified date, during which a test result related to the identified medical condition showed a critical value.

The resident’s family was interviewed and recalled that the resident was exhibiting two of

the signs and symptoms related to the identified medical condition. The family also stated that PSWs informed them that, during that time, the resident was exhibiting a third sign and symptom, and the family said they had inquired to staff about one of the resident’s sign and symptom on multiple occasions. The resident's family acknowledged that they had never heard anything about the resident having the identified medical condition in the past. The resident’s family said that the resident’s test result related to the medical condition was very high, and that several medical staff members external to the home told them that the resident's symptoms should have led the home to perform a test on resident related to the identified medical condition. The resident's family stated that they believed the home failed to diagnose the resident with identified medical condition and treat the resident.

During interviews, an RPN, an RCA, and a PSW all stated that the resident exhibited one of the signs and symptoms related to the identified medical condition.The PSW also recalled that the resident exhibited two other signs and symptoms related to the identified medical condition.

The Physician was interviewed and stated that the resident did not have the identified medical condition. The Physician said that they never received report from staff that the resident had exhibited any of the three identified signs and symptoms related to the identified medical condition. The Physician added that the resident did not exhibit symptoms of identified medical condition until the day the resident was sent for further medical evaluation.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident’s care needs changed.

The severity of this issue was determined to be a level three as there was actual harm, and the scope was isolated during the course of this inspection. This area of non-compliance was previously issued as: a compliance order (CO) during a Resident Quality Inspection (RQI) (#2017_606563_0008) issued on June 19, 2017, with a due date of July 28, 2017; a CO during a Complaint inspection (#2017_457631_0003) issued on February 9, 2017, a Voluntary Plan of Correction (VPC) during a RQI (#2016_271532_0011) on May 3, 2016; a VPC during a RQI (#2015_325568_0011) on March 16, 2015; a CO during a Critical Incident System inspection (#2015_226192_0008) issued on February 27, 2015. [s. 6. (10) (b)]

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.