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
Mar 26, 2018	2018_580568_0002	002064-18	Complaint

Licensee/Titulaire de permis

peopleCare Inc.
650 Riverbend Drive Suite D KITCHENER ON N2K 3S2

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

DOROTHY GINTHER (568)

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): January 29, 30, 31, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Executive Director of Nursing, Director of Resident Care, Registered Practical Nurses, and Personal Support Workers.

The inspector also reviewed the investigation notes related to the complaints, the identified resident's clinical record, and relevant policies / procedures. They conducted observations of care being provided to the identified resident and other residents in the home, their environment, and interactions between staff and the resident.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Reporting and Complaints
Skin and Wound Care

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was unable to toilet

independently some or all of the time received assistance from staff to manage and maintain continence.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) in regards to care not being provided to a resident on a specified date. During a conversation with the complainant they shared that on a specified date while in the presence of the identified resident, they were not taken to the toilet or changed over a more than five hour time period.

In a review of the identified resident's most recent Minimum Data Set (MDS) assessment it was found that the resident was incontinent of both bowel and bladder to some degree. The plan of care for bowel and bladder continence included several interventions including the use of an incontinent product and scheduled toileting. The Kardex for toileting stated that the resident required staff assistance and that the resident was to be offered toileting at specified times.

In an interview with a Personal Support Worker (PSW) they said that they had worked on the identified resident's home area on the specified date. The staff member shared that they were short one staff on their shift that day. When asked if they recalled providing care for the identified resident that day, the PSW said they assisted another PSW with the resident's care in the morning which included toileting the resident. When asked if they had toileted the resident again during their shift that day the PSW said they had not.

During an interview with a second PSW that worked the same shift on the specified date they recalled being short of staff as well, with just two PSWs on the home area instead of three. When asked if they remembered providing care for the identified resident that day, they said that they remembered providing care in the morning which included toileting. When asked if they had toileted / changed the resident before or after meals, they could not recall.

In an interview with the Director of Resident Care (DRC) and Executive Director of Nursing (EDON) they said that as part of their investigation they had interviewed care staff working on the home area on the specified date and they reviewed the PSW documentation for the same time period. The EDON said they had reviewed the staffing schedule for that day and noted that the home area had been short one PSW. Based on their investigation they agreed that it was unlikely that the identified resident was toileted / changed during the time period identified by the complainant.

The licensee failed to ensure that the identified resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence. [s. 51. (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 the resident who is unable to toilet independently some or all of the time receives the assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Record review identified a Complaint Record Form with a specified date.

During an interview with the DRC and EDON, they said that upon receipt of the complaint they initiated an investigation immediately. The EDON stated that they had not reported the incident to the Ministry of Health and Long Term Care as they had a complaint in relation to the same resident and had forwarded this to the MOHLTC. When asked if there were reasonable grounds to suspect either improper care or neglect of the identified resident, the EDON said that there was.

The licensee failed to ensure that a person who had reasonable grounds to suspect that a resident was not properly cared for and there was a potential risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director: [s. 24. (1)]

Issued on this 28th day of March, 2018

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

Original report signed by the inspector.