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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 12, 2018	2018_735659_0010	008117-18	Resident Quality Inspection

Licensee/Titulaire de permis

peopleCare Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

JANETM EVANS (659), NUZHAT UDDIN (532), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 24, 25, 26, 27, 30 and May 1, 2, 3, 4, 7, 8, 9, 10 and 11, 2018.

The following follow up and intakes were completed in conjunction with the RQI:
Log #012381-17 Follow up to Compliance Order #001 related to plan of care
Log #021547-17 Complaint related to nursing and personal support services
Log #001673-18 Complaint related to restraint policy
Log #016501-17 Complaint related to nursing and personal support services
Log #017530-17 Complaint related to nursing and personal support services

Log #028843-17\IL-54578-LO Complaint related to nursing and personal support services
Log #002687-18\IL-55328-LO Complaint related to nursing and personal support services
Log #001345-18\IL-55050-LO Complaint related to nursing and personal support services
Log #013161-17\2606-000010-17 Critical incident related to fall
Log #025167-17\2606-000021-17 Critical incident related to fall
Log #025289-17\2606-000022-17 Critical incident related to fall
Log #028614-17\2606-000023-17 Critical incident related to fall
Log #029271-17\2606-000028-17 Critical incident related to medication administration
Log #029634-17\2606-000030-17 Critical incident related to alleged neglect
Log #007246-18\2606-000008-18 Critical incident related to alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director, Executive Director of Nursing (EDON), Assistant Executive Director/Director of Food Services, Corporate Consultant, Director(s) of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Behaviour Support Ontario lead (BSO), Personal Support Workers (PSW), Staffing and Scheduling Manager, Recreationist, Dietitian, Dietary Aide and Environmental Services.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, staffing schedules and clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, staff to resident interactions, infection prevention and control practices, general maintenance and cleanliness of the home and required postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2017_606563_0008	633

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A. Review of the clinical record for an identified resident showed the resident was assessed as having an altered continence status and required extensive assistance from staff for continence management.

Review of the current care plan for the identified resident, documented that an assistive device was to be used at the bedside for continence management. The identified resident's care plan stated see continence focus but there was no documented continence focus in the resident's care plan.

A Registered Practical Nurse (RPN) stated the identified resident had an altered continence status and that interventions for continence should be in the care plan and tasks should be created for the PSWs.

Director of Resident Care (DRC) stated that the identified resident required assistance of one staff for continence management. The DRC stated that staff would know the resident's needs related to continence from the care plan and tasks. The DRC stated the identified resident should use an assistive device at the bedside for continence management; the DRC acknowledged the identified resident's care plan did not document continence needs.

B. Review of the clinical record for an identified resident documented an assessment which indicated the resident required the use of a device for safety and positioning.

Review of Point of Care (POC) for a specified time showed a task related to the use of a

device.

Review of the current care plan did not show documentation related to the use of a device.

Review of the licensee's policy Care Plan and Plan of Care , 005415.00 documented: "The plan of care must include:
1. The planned care for the resident
2. The goals the care is intended to achieve
3. Clear directions to staff and other who provided direct care to the resident"

A Personal Support Worker (PSW) stated the identified resident required a device which was to be removed and reapplied every two hours.

A Registered Practical Nurse (RPN) stated they were not certain why the identified resident used a device. They stated nurses should have updated the care plan.

Director of Resident Care (DRC) stated that the device should be documented in the identified resident's care plan.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (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 plan of care will set out clear directions related to continence care and bowel management and use of devices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. Review of the clinical record showed an identified resident was at risk for falls. In October 2017 and March 2018, the identified resident had falls in which they had sustained injuries.

Review of progress notes for April 2018, showed the resident had four unwitnessed falls. The identified resident was assessed as having no injury post fall, however one of the post fall assessments for the identified resident documented interventions had been unsuccessful and the fall intervention tasks needed to be updated.

Review of the current care plan for the identified resident documented the resident was at risk for falls; the goal was the identified resident would have decreased injuries and the documented intervention stated to ensure the resident "is washed and dry after incontinence episode to prevent restless".

A review of the licensee's Fall Prevention and Management Program - Falls Risk Factors and Related Interventions, reference #5190.00 documented:
"The Registered Staff will:
- Ensure that preventative interventions are included in the resident's care plan"

Observations completed showed the identified resident used two safety devices.

Two PSW's and one Registered Practical Nurse (RPN) verbalized safety devices used to prevent falls for the identified resident. An RPN stated they usually look for information

related to fall prevention for residents in the care plan.

Director of Resident Care (DRC)/falls lead stated that there were specific tasks for residents at risk of falling. They stated that registered staff use the care plan and the interventions would be put into Point of Care (POC) tasks or the Kardex. The DRC stated that the expectation was that task interventions should be included in the care plan.

Executive Director of Nursing (EDON) stated the care plan was for nurses and tasks direct PSW's to what they need to do.

The licensee has failed to ensure that their Fall Prevention and Management Program - Falls Risk Factors and Related Interventions policy was complied with.

B. The licensee has failed to ensure that the policy "IIA01 medication Administration- General Guidelines" dated 2016 by Hogan Pharmacy Partners was complied with.

The policy "Medication Administration- General Guidelines" Step 17 stated "the resident is always observed after administration to ensure that the dose was completely ingested".

The home's medication incidents in the last quarter were reviewed as a mandatory task of the Resident Quality Inspection (RQI). Two medication incident reports stated: two identified residents had scheduled medications left by the bedside and the residents did not consume them. The medications for one of the identified resident's were discovered by their family member that day and were given later that morning.

A Registered Practical Nurse (RPN) acknowledged the medication incident and said that they should not have left the resident's pills on the table.

The EDOC stated that staff did not follow the home's medication administration policy or the best practices from the College of Nurses of Ontario (CNO) related to safe medication administration. They also said that that the expectation was that medications were given as prescribed by the prescriber and that staff were to ensure that medications were consumed by the resident.

The licensee has failed to ensure that the policy "IIA01 medication Administration- General Guidelines" dated 2016 by Hogan Pharmacy Partners was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 related to ensuring that Fall Prevention and Management Program - Falls Risk Factors and Related Interventions is complied with by ensuring that fall prevention interventions are documented to resident care plans. In addition, the licensee will ensure that "medication Administration-General Guidelines" dated 2016 by Hogan Pharmacy Partners was complied with specific to staff ensuring that they observe residents after administration of medication to ensure the dose was completely ingested, to be implemented voluntarily.

WN #3: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of the clinical record for an identified resident documented the resident's continence status. There was no documented evidence of an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions for the identified resident.

The RPN stated that continence assessments were to be completed on admission to the home and said if it was not on Point Click Care it was not done.

The DRC said the expectation was continence assessments would be documented online, the DRC acknowledged that continence assessments had not been completed for the identified resident.

The licensee has failed to ensure that the resident who was incontinent received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (a)]

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 incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A critical incident (CI) was submitted to the Ministry of Health and Long-Term care (MOHLTC) in December 20, 2017, by the Executive Director of Nursing (EDON). The CI stated that the identified resident received the wrong medication by a Registered Practical Nurse (RPN) in December 2017, and the identified resident was transferred to the hospital for monitoring.

The plan of care in Point Click Care (PCC) stated that the identified resident had a specified medical diagnoses and required an injection of a specified medication at bedtime.

The EDON said that their expectation was that the identified resident received their medications as prescribed.

The licensee has failed to ensure that the identified resident's medication was given in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

In April 2018, there was a witnessed physical altercation between two identified residents. The Recreationist separated the two residents and reported the incident to a Personal Support Worker (PSW) as the nurse was on break.

The home's policy Abuse or Suspected Abuse/Neglect of a Resident, reference # 005010.00 stated that " there is Zero tolerance for abuse/alleged abuse and neglect. It applies directly to all staff, residents, volunteers, family members and visitors of the home". The documented procedure included :

The charge nurse will:
3. Notify DOC/ED immediately"

The Registered Practical Nurse (RPN) stated that they had received a note from a PSW about the incident. They assessed both residents, completed a Risk Management note and notified the Substitute Decision Makers for both residents. The RPN stated the only thing they did not do was to notify the Executive Director of Nursing (EDON).

The EDON stated that they were on call. They found out about the incident when reviewing the note online from their home. They later attended the home to initiate an investigation and complete and submit a Critical Incident (CI). The EDON stated that they had recently completed training with registered staff related to mandatory reporting and abuse and the RPN was in attendance and knew they should have reported the incident.

The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that corrective action was taken as necessary.

The home's medication incidents in the last quarter were reviewed as a mandatory task of the Resident Quality Inspection (RQI).

The home's medication incident records stated that a Registered Practical Nurse (RPN) left an identified resident's scheduled medications on a specified date with the resident in their room. The incident report stated that the resident's substitute decision maker (SDM) had requested that the identified resident's chart be updated to include that medications were not to be left with the resident and staff were to witness the resident taking their medications.

The resident's profile, electronic medication administration record (eMAR) and care plan in Point Click Care (PCC) did not include this corrective action as requested by the family of the identified resident.

The RPN acknowledged the medication incident and agreed that the identified resident's care plan was not updated.

The EDOC stated that the expectation was that the plan of care for the identified resident should have been updated and it was not.

The licensee failed to ensure that corrective action was taken related to the medication incident that occurred involving the identified resident [s. 135. (2)]

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

---

Issued on this 5th day of July, 2018

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

Original report signed by the inspector.