Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 10, 2019 | 2019_821640_0029 | 015453-19 | Complaint |

## 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

HEATHER PRESTON (640)

## 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): November 4, 5, 6, 7, 14 and 15, 2019.**

**During the course of the inspection the LTCH Inspector toured the home, interviewed residents, family and staff, observed the provision of care, reviewed staffing schedules, clinical records, policy and procedures.**

**The following Complaint Inspection was reviewed:**

**IL-69112-CW, Log #015453-19 related to concerns about short staffing, late medication administration and food quality.**

**PLEASE NOTE: This inspection was conducted concurrently with Critical Incident inspection #2019_821640_0030.**

**During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Environmental Support staff, RN in Charge of Admissions, RAI Coordinator, Fall Program Lead, Directors of Resident Care (3), Acting Staffing clerk, Executive Director of Nursing Care (EDONC) and the Executive Director (ED).**

**The following Inspection Protocols were used during this inspection:**
**Food Quality**
**Medication**
**Personal Support Services**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **1 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 | Légende<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. |

**WN #1: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every medication incident involving a resident was (a) documented and (b) reported to the resident, the resident's substitute decision maker (SDM), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or registered nurse in the extended class and the pharmacy service provider.

As a result of a complaint regarding the home being short staffed resulting in an allegation of medications being administered late, the Long-Term Care Homes (LTCH) Inspector interviewed staff at the home. RN #101, RPN #103 and RPN #106 said that recently, there was a day in which one home area did not have a registered staff to administer medications and treatments.

The licensee's pharmacy service provider policy "Medication Incident Reporting and Management", policy #IIA06A, directed registered staff to report any medication incident to a Pharmacist. It noted that a medication error was any preventable event that may cause a patient harm. Such events may be related to professional practice, procedures, systems and administration.

The licensee's pharmacy service provider policy "Administration Procedures for All Medications", policy #IIA001 stated that one guiding principle was timeliness. Registered staff were directed to administer medications based on the administration times posted in the Medication Administration Record (MAR), in accordance with best practice for timely administration. The policy referenced the acute care facility guidelines recommended by Institute of Safe Medication Practices (ISMP) which stated medications could be safely

given within 30 minutes of the prescribed time. The policy stated as part of the procedure, staff were to review the eight "rights" of medication administration prior to administering the medication, one of which is the correct time.

The licensee's policy "Medication Incident Reporting", policy #011110.00, directed registered staff to notify the attending physician, Director of Care and the pharmacy of the incident. A progress note was to be made detailing the incident and notification of the resident or their SDM. A follow up assessment was required. The "Medication Incident Reporting Form" was to be reviewed by the Director of Resident Care daily. All medication incidents were to be documented, reviewed and analyzed and corrective action taken.

The LTCH Inspector reviewed random “Medication Administration Audit Reports” for residents from two affected home areas for the 0800-hour medication pass for an identified date in November. Seven of the eight residents reviewed had been administered medications and/or treatments late and outside of an acceptable time frame.

The LTCH Inspector requested all medication incident reports from the EDONC for a specific period of time. The documents provided included one medication incident of omission not related to the day reviewed.

RN #101 and RPN #106 reviewed the results of the reports with the LTCH Inspector. They said they believed there was an hour window before and after the prescribed time of administration to administer the medication to the resident. They said that in the cases reviewed, they were over the hour time period and that this would constitute a medication incident.

RPN #106 said they had not informed anyone, nor had they completed any medication incident reports.

Resident #011 was administered their high risk medications over one hour after the prescribed time. Their specific test reading scheduled for 0730 hours, before breakfast, was not done until 0930 hours.

Resident #006 was administered their 0730-hour high risk medications at 0952 hours. Their specific test reading, scheduled for 0730 was done at 0952 hours.

RPN #106 said there had not been any observation or documentation for either resident related to their response to the late administration of their high risk medications.

The licensee failed to ensure that all medication incidents were documented and reported. [s. 135. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

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

**s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that there was a written staffing plan for nursing and personal support services that included a staffing mix that was consistent with residents assessed care and safety needs, that set out the organization and scheduling of staff shifts and promoted continuity of care by minimizing the number of different staff members providing care to each resident.

During a review of a complaint regarding the home being regularly short staffed, the LTCH Inspector requested a copy of the staffing plan from the EDONC. They provided a document labelled "Hilltop – ultimate staffing" dated April 19, 2019. The EDONC was asked if that were the only components to the home's staffing plan. They said that was all they had.

This document listed how many hours the DOC, RNs, ARDCs, RAI nurses, RPNs, BSO staff, PSWs and ward clerks were to be scheduled daily and weekly. The report did not direct which staff were scheduled on which home area based on the assessed care and safety needs of the residents. It did not demonstrate the organization and scheduling of shifts nor how it promoted the continuity of care by minimizing the number of different

staff members providing care to each resident.

The ED said the document was what the home submitted to their Head Office as their nursing department budgeted hours.

The contingency plan for registered staff shortages and work short protocol for PSWs was provided later by the ED.

The “Work Short Protocol for PSW” gave direction how to reassign other PSWs on each shift and that the On-Call Manager or DRCs would be called to assist with transfers, toileting, portering, feeding, bedmaking and dressing of residents. The document directed that baths and showers that were missed due to the staff shortage, were to be rescheduled to the next immediate time that met the resident’s needs and wishes.

The “Nursing Contingency for Registered Staff Shortages” directed that all registered staff be called, and overtime offered. An extra PSW was to be scheduled for the affected home area. If the shift was not replaced, all other nurses from the other home areas were required to provided medications and treatments and respond to emergencies along with their regular duties for their own 30 residents.

The licensee failed to ensure there was a written staffing plan for the nursing and personal support services program that included a staffing mix that was consistent with residents assessed care and safety needs, that set out the organization and scheduling of staff shifts. [s. 31. (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 the licensee must ensure that there is a written staffing plan for nursing and personal support services that includes a staffing mix that is consistent with residents assessed care and safety needs, that setd out the organization and scheduling of staff shifts and promoted continuity of care by minimizing the number of different staff members providing care to each resident, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

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

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure that residents were bathed, at a minimum, twice per week by the method of their choice.

As a result of a complaint about short staffing from a family member and staff of the home, the LTCH Inspector reviewed actual worked staffing schedules and bathing documentation for six residents.

The complainant stated they believed residents were missing some of their baths due to staff shortages. During interviews with RN #101, RPN #103, PSW#102 and Environmental Services (ES) staff #105 on two home areas, they stated that the home is often short staffed and on a particular date, they were short staffed and were not able to complete all baths that day.

The licensee's "Work Short Protocol for PSW Hilltop Manor", with a hand written reviewed date of May 2017, directed that baths and showers that were not completed during staff shortages were to be rescheduled at the next immediate time best meeting the needs and wishes of the resident.

The LTCH Inspector reviewed six resident records as per PSW #102 and RPN #103 recommendations.

RPN #103 said they were short staffed in nursing and PSWs on an identified date and staff had reported not all baths had been completed. They had not documented the missed baths.

Documentation survey reports were run for residents #008, #009, #011, #012, #013 and #014.

Residents #008, #009 and #012 did not have their baths completed as scheduled in their plan of care.

They were not provided an alternate bath but did receive their next bath of the week.

Resident's #011, #013 and #014 were provided their bath later in the day.

The licensee failed to ensure that residents #008, #009 and #012 received their twice weekly bath or shower.

***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 the licensee must ensure that residents are bathed, at a minimum, twice per week by the method of their choice, to be implemented voluntarily.***

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**Issued on this 19th day of December, 2019**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | HEATHER PRESTON (640) |
| **Inspection No. / No de l'inspection :** | 2019_821640_0029 |
| **Log No. / No de registre :** | 015453-19 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Dec 10, 2019 |
| **Licensee / Titulaire de permis :** | peopleCare Inc.<br>735 Bridge Street West, WATERLOO, ON, N2V-2H1 |
| **LTC Home / Foyer de SLD :** | peopleCare Hilltop Manor Cambridge<br>42 Elliott Street, CAMBRIDGE, ON, N1R-2J2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Mike Dickin |

To peopleCare Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

**Order / Ordre :**

The licensee must comply with s. 135 (1) of O. Reg 79/10.

Specifically, the licensee must:

1) Ensure that all medication incidents are reported using the licensee's documentation process and,

2) Ensure that all medication incidents are reported to all parties named in s. 135 (1).

**Grounds / Motifs :**

1. The licensee failed to ensure that every medication incident involving a resident was (a) documented and (b) reported to the resident, the resident's substitute decision maker (SDM), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or registered nurse in the extended class and the pharmacy service provider.

As a result of a complaint regarding the home being short staffed resulting in an allegation of medications being administered late, the Long-Term Care Homes (LTCH) Inspector interviewed staff at the home. RN #101, RPN #103 and RPN

#106 said that recently, there was a day in which one home area did not have a registered staff to administer medications and treatments.

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Resident #006 was administered their 0730-hour high risk medications at 0952 hours. Their specific test reading, scheduled for 0730 was done at 0952 hours.

RPN #106 said there had not been any observation or documentation for either resident related to their response to the late administration of their high risk medications.

The licensee failed to ensure that all medication incidents were documented and reported. [s. 135. (1)]

The severity of this issue was determined to be level 2, minimal harm, minimal risk. The scope of this issue was determined to be widespread. Eight of nine residents reviewed had medications administered outside of the prescribed time. The compliance history was determined to be level 3. Previous non-compliance to the same section of the LTCHA as follows:

- VPC issued Jun 17,2017, under Inspection # 2017_606563_0008 (640)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Feb 28, 2020

Ontario

## Ministry of Long-Term Care

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ministère des Soins de longue durée

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 10th day of December, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Heather Preston

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office