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 7, 2020	2020_835767_0017	017364-20, 018236-20, 018800-20, 018801-20, 018802-20, 018803-20	Critical Incident System

Licensee/Titulaire de permis

peopleCare Communities 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

SARAH INGLIS (767), NUZHAT UDDIN (532), VALERIE GOLDRUP (539)

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): October 27-30, and November 2, 2020

The following intakes were inspected within this Critical Incident Inspection; follow up intakes; log #018803-20 to CO #001 from inspection #2020_73853_0017 and log #018802-20 to CO#002 from inspection #2020_738753_0017 related to medications. Log #018800-20 to CO #003 from inspection ##2020_738753_0017 and log #018801-20 to CO #004 from inspection #2020_738753_0017 related to falls. Also, within this the Critical Incident Inspection; log # 018236-20 and log #017364-20 related to falls.

PLEASE NOTE; This Critical Incident inspection was completed concurrently with a Complaint Inspection # 2020_835767_0018.

During the course of the inspection, the inspector(s) spoke with the Executive Director of Nursing (EDON), Resident Director of Care, (RDOC), a Registered Nurse's, a Registered Practical Nurse (RPN) and Personal Support Workers (PSW's).

The inspectors toured resident home area's; observed resident care provision, administration of medications and resident staff interactions. They also reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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
O.Reg 79/10 s. 131. (2)	CO #002	2020_738753_0017	532
O.Reg 79/10 s. 135. (1)	CO #001	2020_738753_0017	532
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #004	2020_738753_0017	539
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2020_738753_0017	539

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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A resident sustained an injury, was transferred to hospital and returned to the LTC home the same day with a significant change in their health condition.

A Critical Incident System (CIS) Report was submitted to the Ministry of Long-Term Care (MLTC) two weeks after the incident, at the time of the resident's death.

There was no risk related to the late submission of the CIS report to the Director.

Sources: CIS Report, the resident's progress notes, interview with DRC and other staff. [s. 107. (3) 4.]

Issued on this 14th day of December, 2020

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

Original report signed by the inspector.