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

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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_0018	018617-20, 020569-20	Complaint

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), VALERIE GOLDRUP (539)

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

The following intakes were inspected during this inspection; log #018617-20 related to abuse and log #020569-20 related to neglect.

PLEASE NOTE: This Complaint Inspection was completed concurrently with a Critical Incident inspection # 2020_835767_0017

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

During the course of this inspection the inspectors observed resident home areas, provision of resident care, resident and staff interactions; reviewed relevant resident clinical records; reviewed homes investigation notes; and other pertinent documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect by two staff.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.”

A resident was assisted to the washroom by two staff and provided with a call bell. Staff did not check to ensure the resident could activate the bell. A registered staff found the resident 40 minutes later calling out and upset as they were still on the toilet. The registered staff said someone should have checked on the resident during that time.

There was a risk of actual harm to the resident having been left on the toilet for an extended period of time with no monitoring or supervision.

Sources: The LTCH investigation notes; the resident's progress notes; Interview with the resident and staff involved in the incident. [s. 19. (1)]

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 all residents are kept free from neglect, to be implemented voluntarily.

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.