

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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport No de l'inspection

Inspection No /

Loa #/ No de registre Type of Inspection / **Genre d'inspection**

Aug 25, 2021

2021_729615_0025 010600-21

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 16 and 17, 2021.

The following intake was inspected during this inspection: Complaint Log #010600-21 related to food quality.

Critical Incident Inspection #2021_729615_0026 was completed in conjunction with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Executive Director of Nursing, the Director of Resident Care, the Director of Food Services, a Dietary Aid and a Personal Support Worker.

The inspector also toured the home, observed Infection Prevention and Control practices, residents and the care provided to them, reviewed the resident's clinical records, the home's policies and procedures and other relevant documents.

The following Inspection Protocols were used during this inspection: Food Quality
Infection Prevention and Control
Personal Support Services

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)



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| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|--|
| Legend | Légende |
| WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order | 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). | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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. 68. Nutrition care and hydration programs



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Specifically failed to comply with the following:

- s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
- (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
- (b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
- (c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
- (d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
- (e) a weight monitoring system to measure and record with respect to each resident,
 - (i) weight on admission and monthly thereafter, and
- (ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants:

1. The licensee has failed to ensure that the hydration program included the identification of any risks related to beverage temperature and the implementation of interventions to mitigate and manage those risks.

A complaint was submitted to the Ministry of Long Term Care (MTLC) related to concerns of a resident having sustained injuries as a result of an incident involving their hydration. An incident occurred where a resident sustained injuries and was screaming in pain related to the lack of monitoring of fluid temperatures. The Director of Food Services stated that the home did not have a policy and procedure related to the monitoring of fluid temperatures.

Sources: complaint report, resident's clinical records, interviews with the Director of Food Services, a Dietary Aid and a Personal Support Worker. [s. 68. (2)]



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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 hydration program include the identification of any risks related to beverage temperature and the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

Issued on this 26th day of August, 2021

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

Original report signed by the inspector.