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
Nov 9, 2021	2021_823653_0029	015339-21, 016163-21, 016282-21	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

ROMELA VILLASPIR (653)

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): November 3-5, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #015339-21 was related to falls prevention and management;
Log #016163-21 was related to falls prevention and management, and unexpected death of a resident;
Log #016282-21 was related to an allegation of improper care resulting in a fall with injury.

Complaint inspection #2021_954618_0003 was completed in conjunction with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Agency PSWs, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Directors of Resident Care (DRCs), and the Executive Director of Nursing Care (EDNC).

During the course of the inspection, the inspector observed provision of care, reviewed clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that different approaches had been considered in the revision of a resident’s plan of care, when they were reassessed and the plan of care was revised because care set out in the plan had not been effective.

A resident was at risk for falls and had multiple falls within two consecutive months. After four different fall incidents, no new interventions were added to the resident’s plan of care, and they continued to sustain falls.

The Director of Resident Care (DRC) acknowledged that the registered staff did not make a note that the plan of care was reviewed and that changes were made to the resident's falls interventions, as required.

By not considering different approaches with regards to falls interventions, there was potential for further fall incidents to occur.

Sources: Resident’s clinical health records; Interviews with the Personal Support Worker (PSW), Registered Practical Nurse (RPN), Physiotherapist (PT), and the DRC. [s. 6. (11) (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 to ensure that when a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

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Issued on this 10th day of November, 2021

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

Original report signed by the inspector.