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

**Central East Service Area Office**
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

**Original Public Report**

**Report Issue Date** September 20, 2022
**Inspection Number** 2022_1117_0001
**Inspection Type**
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
PeopleCare Communities Inc.

**Long-Term Care Home and City**
PeopleCare Hilltop Manor, Cambridge

**Lead Inspector** **Inspector Digital Signature**
Helene Desabrais (615)

**Additional Inspector(s)**
Nuzhat Uddin (532)
Maya Kuzmin (741674)

## INSPECTION SUMMARY

The inspection occurred on the following date(s): July 19, 20, 21, 22, 25, 26, 27, 28, 29, August 2, 3 and 4, 2022.

The following intake(s) were inspected:

- Intake #012672-22 related to skin and wound prevention and management;
- Intake #011939-22 related to prevention of abuse and neglect;
- Intakes #010153-22, #007975-22, #002115-22, # 000741-22 related to falls prevention and management;
- Intakes #003594-22, #002880-22 related to unexpected death;
- Intake #012880-22 (Complaint) related to food, nutrition and hydration;
- Intake #012307-22 (Complaint) related to prevention of abuse and neglect.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours

- Skin and Wound Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION [PLAN OF CARE]

**NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

Non-compliance with: FLTCA, 2021, s. 6(11)(b).

The licensee has failed to ensure that different approaches were considered when a resident's plan of care was revised because the plan had not been effective.

A complaint was submitted to the Director related to a resident's weight. The complainant stated they brought their concerns about the resident's weight and its impact on the resident's overall health to the home many times, however, nothing was really done to help the resident to lose weight. The resident's BMI had increased since admission.

A Registered Dietician (RD) said they received a referral from the home's physician two years ago to assess the resident. Following an assessment, they implemented interventions to control the resident's intake, but they were not effective.

A Registered Practical Nurse – Behavioural Support Ontario (RPN-BSO) stated if a resident exhibited the identified behaviour and was gaining a lot of weight it would be considered a responsive behaviour.

There had been no assessment completed since the resident's admission to the home to identify possible behavioural triggers and, no strategies developed or implemented for the identified behaviours, or any other actions taken beyond a referral to the RD.

The staff's failure to consider different approaches in the revision of the resident's plan of care put the resident's overall health at risk.

Sources: Complaint Log #012880-22, a resident's clinical records, interviews with an RN, an RPN-BSO, an RD and the DOC.

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### WRITTEN NOTIFICATION [RESPONSIVE BEHAVIOURS]

**NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

Non-compliance with: Reg. 246/22 s. 58 (4)(c).

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours that actions were taken to respond to the needs of the resident, including

assessments, reassessments, and interventions and that the resident's responses to interventions were documented.

The home's policy "Responsive Behaviours – Behavioural Interventions" (No date) which was captured in the licensee's responsive behaviours management program directed staff to complete a DOS charting by a PSW staff to monitor, observe and integrate assessment findings and collaboratively problem solve for possible solutions.

A Registered Practical Nurse – Behavioural Support Ontario (RPN-BSO) stated, in this incident, that a resident's behaviours were increasing in the early morning and a DOS was initiated later that morning to monitor and observe the resident's behaviours. The resident's DOS indicated that the monitoring did not start until approximately 11 hours later that day after an incident of abuse involving the resident towards another resident that resulted in injuries. No documentation was found of the escalated behaviours and interventions to respond to those behaviours.

The PSW-BSO stated that they missed completing the DOS for the resident. The resident did not have one-to-one support after the PSW-BSO's shift ended.

The staff's failure to complete the DOS monitoring and observation prevented the home from recognizing and responding to the resident's responsive behaviours.

Sources: A resident's progress notes, the CIS, DOS charting documents, interviews with an RPN-BSO, a PSW-BSO and other staff.

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## WRITTEN NOTIFICATION [NOTIFICATION RE INCIDENTS]

**NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

Non-compliance with O. Reg. 246/22, s.104. (2)

The licensee has failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation, immediately upon the completion of the investigation.

The home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident" section titled "Care Monitoring" (No date) directed staff to notify the resident and SDM of the outcome of the investigation with as much detail as possible without breaching confidentiality when the investigation is completed.

The EDOC acknowledged that they did not notify the two residents' SDM of the results of the home's investigation into an incident of abuse.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference no. 005010.00 and interview with the EDOC.

[532]

## WRITTEN NOTIFICATION [PAIN MANAGEMENT]

**NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

Non-compliance with O. Reg. 246/22, s. 57. (1) 2.

The licensee has failed to ensure that the pain management program for a resident provided for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices, and assistive aids.

A resident had three consecutive falls, in one day, resulting in injuries and a hip fracture that was not diagnosed until two days after. The Pain Assessment in Advanced Dementia Scale (PAINAD) identified the resident as having pain.

Progress notes from a physiotherapist and nursing staff indicated that the resident showed signs and symptoms of pain.

The Director of Care (DOC) said that for the two days, the resident was not given anything for pain.

The resident remained in pain for two days when the home failed to provide the resident with pain management strategies.

Sources: the resident's progress notes, e-MARS, PAINAD, the CIS, interview with the DOC and other staff.

[532]

## COMPLIANCE ORDER [CO#001] [POLICE NOTIFICATION]

**NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: O. Reg. 246/22, s. 105

**The Inspector is ordering the licensee to:**

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this ActFLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

**Compliance Order** [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 105.

The licensee shall:

a) Conduct an audit of all documented incidents of alleged, suspected or witnessed abuse to ensure police are immediately contacted for those incidents where a criminal offence may have been committed. The audit must include a record of the incidents, review of interviews / statements provided by witnesses and decision notes related to whether the incidents constitute a criminal offence for a period of two weeks.

b) Provide training to the management of the home, including but not limited to the EDOC, the DOC, the ADOC's and the Administrator in relation to the reporting requirements of a criminal offence. This training should include education on what may constitute a criminal offence. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

c) The Abuse Policy should include clear directions in relation to contacting the appropriate police force for incidents of alleged, suspected or witnessed incidents of sexual abuse that may constitute a criminal offence.

## Grounds

Non-compliance with: O. Reg. 246/22, *s. 105.*

The licensee has failed to ensure that the appropriate police force was immediately notified of a suspected incident of abuse by a resident that may have constituted a criminal offence.

A PSW said they witnessed one resident exhibiting inappropriate behaviours that were directed towards another resident. The PSW stated that they reported the incident to an RPN. They did not call the police as that was typically done by the home's management.

The home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident" (No Date) stated that the Executive Director/DOC will provide direction to the charge nurse regarding the notification of the police.

The EDOC stated that they were unaware they had to call the police immediately.

The licensee's failure to immediately report the suspected abuse to the police resulted in no police investigation being initiated and no direction provided by police to the home on how to properly conduct their own investigation into the incident.

Sources: A resident's clinical records, a CIS, interviews with a PSW, a Physician and the EDOC.

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**This order must be complied with by** November 9, 2022

## COMPLIANCE ORDER [CO#002] [POLICY TO PROMOTE ZERO TOLERANCE]

**NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: FLTCA, 2021, s. 25(1)

**The Inspector is ordering the licensee to:**

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this ActFLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

**Compliance Order** [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 25(1)

The licensee shall:

a) Ensure that all staff, including the management team, are retrained on the LTCH's abuse policy. Document the education including the date, format and staff attending the training, including the staff member who provided the education.

b) Conduct weekly audits for one month following the training to ensure that the following is completed for all incidents of alleged, suspected or witnessed abuse:
i) residents' head-to-toe assessments for injuries are documented in the resident's clinical record,
ii) residents' risk management,
iii) the incident is immediately reported to the home's physician, or physician on-call, and the physician's response documented in the resident's clinical record,
iv) documentation of consent from the SDM when obtaining photographs of a resident.
v) written documentation of the audit including the person who conducted the audit, what was reviewed in the audit, date the audit was conducted, the outcome of the audit, and corrective actions taken must be maintained in the Home.

**Grounds**

Non-compliance with: FLTCA, 2021 s. 25(1).

The licensee has failed to ensure that the long-term care home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A PSW said they witnessed resident #005 exhibiting inappropriate behaviours that were directed towards resident #006.

A) The home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident" (No Date) directed staff when managing incidents of resident-to-resident abuse that the immediate actions are to assess for injuries and complete a risk management.

1) Resident #006's progress notes, on that evening, written by the EDOC stated, in part, that they directed the RPN to assess the resident. There was no documented evidence that an RPN assessed the resident immediately after the incident. An RN said they started their shift two hours after the incident and were asked to complete a head-to-toe assessment and take pictures related to the incident. No risk management was completed.

The EDOC and an RPN's failure to assess the resident immediately after the incident caused a risk that injuries were not identified, and evidence not collected promptly or as required.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference no. 005010.00, the resident's clinical records and an RN.

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2) Subsequently that evening, a PSW said they found resident #005, exhibiting inappropriate behaviours towards resident #007.

No risk management or assessment of injuries was completed for resident #005 and resident #007 following the second incident.

The EDOC said that they were not aware that an assessment of injuries for resident #007 was not completed, and they did not expect an assessment to be completed for resident #005. The EDOC was also not aware that a risk management was not completed as stated in the policy.

Not completing the risk management or an assessment of the residents placed both residents at high risk of harm as the staff were not able to identify the potential injury to either resident.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference no. 005010.00; interview with a PSW and the EDOC.

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B) The home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident" (No Date) directed the RN in charge to notify the physician and request a full medical examination of the resident if warranted or complete a physician referral.

A resident's clinical records stated that the on-call Physician was contacted after the incident of suspected abuse for a medication order to manage resident #005's inappropriate behaviours. There was no documentation that the on-call Physician was made aware of the incident of suspected abuse towards resident #006 that evening.

The EDOC stated that the home's physician was contacted the next morning about the incident to have them come to the home to complete a medical examination of resident #006.

The licensee's failure to have the resident examined by a physician immediately after the incident meant that injuries were not immediately identified and evidence not collected promptly, if any. There was also a risk that the resident was not properly managed afterward.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference no. 005010.00, the resident's clinical records and a Physician.
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C) The home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident" (No Date) directed staff to "Obtain photographs when deemed necessary (obtain appropriate consent)."

A Registered Nurse (RN) said they were directed by the EDOC to take pictures of the resident after an incident of alleged abuse and did not obtain consent from the SDM to take the pictures. The EDOC said they did not ask for consent, but they had directed the RN to take the pictures.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", reference no. 005010.00, the resident's clinical records, interviews with an RN and the EDOC.

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**This order must be complied with by** October 31, 2022

## COMPLIANCE ORDER [CO#003] [DUTY TO PROTECT]

**NC#07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: FLTCA, 2021, s. 24(1)

**The Inspector is ordering the licensee to:**

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this ActFLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

**Compliance Order** [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall:

a) Develop and document a written process that provides direction to direct staff on how to manage incidents of alleged, witnessed, or suspected sexual abuse.

b) Ensure that staff, including the management team are provided education, specifically, on the sexual abuse policy and process including how to intervene when an incident of sexual abuse is occurring.

c) Document the education, as outlined in b), including the date, format, staff attending the training, including the staff member who provided the education.

d) Ensure that an assessment/reassessment is conducted and documented in relation to a resident's behaviours, prior to the discontinuing of one-to-one supervision for residents.

## Grounds

Non-compliance with: FLTCA, 2021 s. 24(1).

The licensee has failed to protect two residents from sexual abuse by a resident.

“Sexual abuse” is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. O. Reg. 256/22. S. 2 (3) (b).

A) In a four-day period, resident #005 exhibited an increase in responsive behaviours.

A Registered Practical Nurse – Behavioural Support Ontario (RPN-BSO) stated that the resident’s behaviours were increasing on the fourth day during the night and a Dementia Observation System (DOS) was initiated later that morning to monitor and observe the resident’s behaviours. However, the DOS was not started until more than 10 hours later following two incidents of suspected abuse.

A Personal Support Worker - Behavioural Support Ontario (PSW-BSO) said they were asked by the Executive Director of Care (EDOC) to provide one-to-one support for that resident on that morning.

An RPN said that the resident was demonstrating responsive behaviours that day; they administered a medication to manage the behaviours prior to supper and the resident settled for a short time. The one-to-one staff left their shift that evening leaving the resident without one-to one supervision.

The RPN stated that during the afternoon huddle with the management team they raised concerns about the resident's escalating behaviours.

Approximately two hours after the one-to-one left for the day, a PSW said they heard screaming coming from a resident’s room. They found resident #005 exhibiting inappropriate behaviours directed towards resident #006.

Resident #006's SDM spent time with the resident following the incident and said they were visibly upset.

A Physician stated they remembered getting help from the nurse to examine resident #006 the following morning as the resident was fearful. During the examination, the physician identified injuries which they attributed to the incident which took place the night before.

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B) Following the incident involving resident #006, resident #005 was supervised by a PSW for a brief period until they left to answer a call by another resident The PSW went to check on resident #005 and found them exhibiting inappropriate behaviours towards resident #007.

Following the incident, a progress note indicated that resident #007 would not have provided consent to engage resident #005.

On an identified date, resident #005 was assigned one-to-one supervision to manage their increased responsive behaviours. The one-to-one supervision was discontinued at the end of the staff's shift without a reassessment of the resident's recent behaviours and without plans for ongoing monitoring. Within two hours, the resident abused two residents in the home.

Failing to protect the two residents resulted in actual harm.

Sources: The three residents' clinical records, the CIS, interviews with the EDOC, an RPN-BSO, an RPN, a PSW-BSO, a PSW and other staff.

[532]

**This order must be complied with by** October 31, 2022

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and

(c) an address for service for the licensee.

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

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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

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