Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: December 8, 2022

Inspection Number: 2022-1117-0003

Inspection Type:
Follow up
Critical Incident System

Licensee: peopleCare Communities Inc.

Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge

Lead Inspector	**Inspector Digital Signature**
Nuzhat Uddin [532]	Nuzhat Uddin Digitally signed by Nuzhat Uddin Date: 2022.12.19 12:54:03 -05'00'

Additional Inspector(s)
Mark Molina [000684]

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 23-30, 2022

The following intake(s) were inspected:

- Intake: #00008765-FUI to Order #001 of inspection 2022_1117_0001 related to O. Reg. 246/22, s. 105, police notification. CDD Nov 9, 2022.
- Intake: #00008767-FUI of Order #002 from inspection 2022_1117_0001 related to FLTCA, 2021, s. 25(1), policy to promote zero tolerance.
- Intake: #00008768-FUI to Order #003 from inspection #2022_1117_0001 related to FLTCA, 2021, s. 24(1), duty to protect.
- Intake: #00011097 was related to resident to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 105	2022_1117_0001	001	Nuzhat Uddin #532
FLTCA, 2021	s. 25(1)	2022_1117_0001	002	Nuzhat Uddin #532
FLTCA, 2021	s. 24(1)	2022_1117_0001	003	Nuzhat Uddin #532

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

Prevention of Abuse and Neglect
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

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 related to safeguarding the resident were implemented and to notify the Charge Nurse to assess for injuries

A critical incident report documented an allegation of resident to resident sexual abuse.

There was no documented evidence that the RPN safeguarded the co-resident immediately after the incident or notified the Registered Nurse (RN).

The Executive Director of Care (EDOC) stated that the Abuse or Suspected Abuse/Neglect of a Resident policy was not implemented as required. The management team was not notified of the incident until the next day. The resident was not safeguarded immediately after the incident, there was no head to toe assessment or risk management completed, no notification to the Substitute Decision Maker (SDM), the police, Ministry of Long Term Care (MLTC), or the physician until the next day.

The registered staff's failure to follow the Abuse or Suspected Abuse/Neglect of a Resident policy in safeguarding the resident immediately after the initial incident caused actual risk of harm as the incident continued to occur.

Sources: Home's policy titled "Abuse or Suspected Abuse/Neglect of a Resident", resident's clinical records, progress notes, risk management, head to toe assessment and interview with the EDOC.

[532]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee failed to ensure that when staff had reasonable grounds to suspect that abuse or improper care of a resident had occurred, that they immediately reported the suspicion to the Director in accordance with s. 28 (1) 2 of the Long-Term Care Homes Act (LTCHA). Pursuant to s.154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary:

A critical incident report documented an allegation of resident to resident sexual abuse.

The alleged abuse was reported one day after the home initially became aware.

The EDOC stated that they were not informed of the alleged abuse until the next day.

By not reporting the alleged incidents of sexual abuse immediately to the Director, it may delay actions required to respond to the incidents, which placed residents at risk of harm.

Sources: Abuse Policy, CIS, progress notes for residents, interview with the EDOC.

[532]

WRITTEN NOTIFICATION: Police notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 alleged sexual abuse by resident #002 that may have constituted a criminal offence.

A critical incident report documented an allegation of resident to resident sexual abuse.

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 not notified of the incident and therefore, the police were also not notified immediately.

The licensee's failure to immediately report the alleged sexual abuse to the police resulted in no police investigation being initiated.

Sources: residents clinical records , CIS, interviews with the EDOC.

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