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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 30, 2023	
Inspection Number: 2023-1117-0004	
Inspection Type: Critical Incident System	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.04.03 12:23:06 -04'00'
Additional Inspector(s) Brittany Nielsen (705769)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 28, March 1-3, March 6-8, 2023

The following intake(s) were inspected:

- Intake: #00020025 related to allegations of staff to resident abuse;
- Intake: #00020506 related to an unexpected death.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that the housekeeping closet located beside a resident room on a Resident Home Area (RHA) was kept closed and locked when the room was not supervised by staff.

Rationale and Summary:
At the time of inspection, a housekeeping closet on a RHA was observed to be unlocked and easily opened as the lever of the lock was stuck inside. Disinfectant chemicals were observed inside the room.

A staff member indicated this had happened before and was shown by other staff how to fix it. They locked the door at that time. A registered staff member was not aware of the issue with the door and submitted a maintenance request at the time of inspection.

Documentation later in the inspection indicated the lock on the door was fixed, and new parts were ordered to be installed.

When the housekeeping door in a RHA was found to be unlocked, there was potential risk to residents when they had access to an unsupervised area that contained disinfectant chemicals.

Date Remedy Implemented: February 28, 2023

[722374]

WRITTEN NOTIFICATION: Visitor Policy

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 267 (1) (c)

The licensee has failed to implement the written visitor policy that complied with all applicable advice or

recommendations issued by a Medical Officer of Health appointed under the Health Protection and Promotion Act.

The home's Visitor Policy documented that any applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act applied to visitors.

Specifically, a Region of Waterloo Public Health Inspector indicated they directed the home not to allow general visitors to areas in outbreak.

Rationale and Summary
Two RHAs had been in an enteric outbreak at the time of inspection.

A Receptionist/Screener stated that general visitors were allowed to visit residents in the two RHAs in outbreak. Documentation indicated there were six general visitors to the two RHAs over two days while in outbreak. Visitation occurred with two residents that had symptoms.

The IPAC Lead acknowledged general visitors should not have been permitted in the two RHAs in outbreak.

Failing to follow the direction from Public Health regarding general visitors to the two RHAs in outbreak put visitors and residents at risk of exposure and the potential spread of the enteric outbreak.

Sources: The home's Visitor Policy, visitor documentation, interviews with a Receptionist/Screener, the IPAC Lead, and a Public Health Inspector from the Region of Waterloo Public Health & Emergency Services, Health Protection and Investigation, Recommendations for the Control of Gastroenteritis Outbreaks in Long-Term Care Homes, Ministry of Health and Long-Term Care.

[722374]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (11) (a)

The licensee has failed to ensure that an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts were in place.

A) In accordance with O. Reg 246/22 s. 11(1)b, the licensee is required to ensure the IPAC program has in place an outbreak management system, including communication plans, and it must be complied with.

Specifically, staff did not comply with the home's Enteric Outbreak Policy that documented the IPAC Coordinator was to review the daily surveillance record for all resident areas and determine whether an outbreak was in progress. The Public Health Unit was to be notified of any suspected outbreak, and daily contact was to take place.

Rationale and Summary
The Region of Waterloo Public Health & Emergency Services Enteric Outbreak Resource Manual documented that whenever there were two suspected cases of infectious gastroenteritis in a specific area within 48 hours, the home was to contact the Region of Waterloo Public Health to support with the investigation and management. A case of infectious gastroenteritis included two or more episodes of diarrhea/watery stool or vomiting within a 24-hour period, or one episode of diarrhea/watery stool and one episode of vomiting within a 24-hour period.

Documentation, indicated two residents experienced two or more cases and one resident experienced one case of gastrointestinal symptoms including diarrhea and/or vomiting in a RHA. Resident cases with similar symptoms continued to be identified over a seven-day period. Cases were identified in a second RHA over three days, at the same time-period. In addition, a specified number of staff members were identified to have symptoms on two dates at the same time-period. The IPAC Lead indicated they started questioning an outbreak eight days after the first symptoms appeared and reported to Public Health ten days after the first symptoms appeared. The home was declared to be in an enteric outbreak when Public Health was notified.

The Region of Waterloo Public Health Inspector indicated the home met the case definition of an enteric outbreak on the first date symptoms appeared, at which time they should have reported. They stated if they had reported the outbreak to Public Health on that date, they could have prevented some of the cases and prevented the spread to the other RHA.

The IPAC Lead acknowledged they should have reported the outbreak sooner to Public Health.

Failing to notify Public Health to receive support with investigating and management of symptomatic residents in the home until ten days after the first cases were identified potentially led to the spread of infectious disease.

Sources: interviews with the IPAC Lead, Public Health Inspector from the Region of Waterloo Public

Health & Emergency Services, Enteric Outbreak Line Listing, Enteric Outbreak Policy, The Region of Waterloo Public Health & Emergency Services Enteric Outbreak Resource Manual, Recommendations for the Control of Gastroenteritis Outbreaks in Long-Term Care Homes, Ministry of Health and Long-Term Care.

B) In accordance with O. Reg 246/22 s. 11(1)b, the licensee is required to ensure the IPAC program has in place an outbreak management system, including communication plans, and it must be complied with.

Specifically, staff did not comply with the home's Enteric Outbreak Policy, that indicated to ensure signage was posted in relation to notifying visitors. The home's Outbreak Checklist documented to post outbreak signage at entrances to buildings.

Rationale and Summary
The IPAC Lead indicated two RHAs were in an enteric outbreak at the time of inspection with residents in isolation. They indicated no general visitors were permitted to those areas at that time.

At the time of inspection, no signage indicating the home was in outbreak was observed on the front doors of the home. A Receptionist/Screener indicated general visitors were being permitted entry.

The IPAC Lead acknowledged signage should have been posted at that time.

Failing to post signage that indicated the home was experiencing an infectious outbreak led to the potential risk related to further spread of infection by not adequately communicating direction to staff and visitors prior to entering the home.

Sources: observations at the time of inspection, interview with a receptionist/screener and the IPAC Lead, Enteric Outbreak Policy, Outbreak Checklist, and Enteric Outbreak Line Listing.

[722374]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154(3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary
The home submitted a CI to the Director reporting allegations of abuse from a staff member to a resident. The staff member, who witnessed the incident of abuse, did not report it to management until two days later.

The Executive Director (ED) acknowledged that the incident should have been reported immediately to the Director.

By failing to report the allegation of abuse immediately, the Director was unable to respond to the incident in a timely manner.

Sources: CI report, the home's investigative notes, Abuse or Suspected Abuse/Neglect of a Resident policy, interviews with a staff member and the ED.

[705769]

WRITTEN NOTIFICATION: Feeding Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that the home used proper techniques to assist a resident with eating on a specified date.

Rationale and Summary
As per the home's Dietary In-Service – Safe Feeding Practices, staff were to assist residents who required care by feeding residents at a moderate pace that they could tolerate and to ensure the resident had fully swallowed before offering more food/fluid. Residents were also to be awake and alert before serving them food/fluid.

A staff member observed another staff member feed a resident using techniques that did not align with their in-service on safe feeding practices. The resident had a negative response to the staff member's approach. The staff member continued to use improper techniques to feed the resident which appeared to leave the resident in discomfort.

The ED stated that it was not okay for a staff member to continue feeding the resident in this manner.

By failing to ensure safe feeding practices were used with a resident, there was a risk of them choking.

Sources: the home's investigative notes, the home's Dietary In-Service – Safe Feeding Practices, interviews with staff members and the ED.

[705769]