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

Original Public Report

Report Issue Date: August 24, 2023

Inspection Number: 2023-1117-0007

Inspection Type:
Critical Incident System

Licensee: peopleCare Communities Inc.

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

Lead Inspector	**Inspector Digital Signature**
Katherine Adamski (#753)	Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.08.29 10:26:24 -04'00'

Additional Inspector(s)
Mark Molina (#000684)
Diane Schilling (#000736)

Jeff Letson was also present for this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 26 - 28, 31, 2023

The following intake(s) were inspected:
- Intake: #00021391 and #00086136 – related to prevention of abuse and neglect
- Intake: #00022326 – related to falls prevention and management
- Intake: #00022802 – unexpected death of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were implemented to respond to a residents responsive behaviours.

Rationale and Summary

An incident occurred between two residents when a resident was exhibiting newly identified responsive behaviours.

The resident's care plan was not reviewed and revised to include strategies in response to the new responsive behaviours resulting in a second incident of a similar nature with another resident.

The Behavioural Support Ontario (BSO) Lead acknowledged that the care plans of both residents did not include strategies to ensure their safety related to the residents responsive behaviours.

When specific strategies related to a residents responsive behaviours were not implemented, residents remained at risk of having a potentially harmful interactions with that resident.

Sources: Observations, medical charting, interviews with BSO Leads and other staff.

[#753]