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: November 30, 2023
Inspection Number: 2023-1117-0010
Inspection Type: Complaint Critical Incident
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge

Lead Inspector	**Inspector Digital Signature**
Craig Michie (000690)	
Additional Inspector(s) Nuzhat Uddin (532)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15-17, 20-23, 2023.

The following intake(s) were inspected:

- Intake: #00094782 was related to fall prevention and management.
- Intake: #00097456 and Intake: #00100521 was related to infection prevention and control.
- Intake: #00098074 - Complaint was related to improper care, visitation and bill of rights.

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

Resident Care and Support Services
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 6.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The licensee has failed to ensure that a resident received visitors of their choice and consult in private with any person without interference.

The Long Term Care Home denied visitation to a family member.

The Home's investigation report and the Ethical Summary report concluded that it was not clear that the family member posed a safety concern to the resident. There was no evidence to restrict visits of family member with the resident and it was recommended to support supervised visits with the family member.

Executive Director (ED) stated that they opted out of the recommendation and supervised visits were not offered to the resident.

Resident's right to receive visitors of their choice was not respected or promoted when the home restricted a family member from visiting the resident and did not provide an alternative arrangement.

Sources: Investigation report, Ethical Summary- Family Access to Resident vs Staff Safety report and interviews with ED and family members.
[532]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes and Other Congregate Living Settings, Version 11, updated June 26, 2023, the required personal protective equipment (PPE) for providing direct care to a resident with confirmed COVID-19 were a fit-tested, seal-checked N95 respirator (or approved equivalent), appropriate eye protection (goggles, face shield, or safety glasses with side protection), gown and gloves.

A signage posted at the entrance of a resident's room indicated that a resident was on droplet contact precautions, which directed staff to wear full personal protective equipment. (PPE), including an N95 respirator when entering the room.

A PSW was observed providing direct care to a resident, who was in droplet precautions, without wearing appropriate personal protective equipment.

The Infection Prevention and Control (IPAC) Coordinator stated that as a result of not wearing appropriate PPE when assisting a resident in droplet precautions and when the resident had active respiratory symptoms, there was a high likelihood of transmission.

Sources: Observation; Minister's Directive: COVID-19 response measures for long-term care homes, Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes and Other Congregate Living Settings; Interview with IPAC Coordinator.
[000690]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document

for long-term care homes in Ontario, updated November 7, 2023, homes must complete IPAC audits weekly when a home is in COVID-19 outbreak.

A Respiratory outbreak was declared on October 28, 2023, and continued to be active as of November 23, 2023. The home was supposed to conduct IPAC Self-Assessment Audits, but it was not completed for the week of November 16, 2023.

IPAC Coordinator acknowledged that the required audits were not completed weekly.

In failing to complete the required weekly IPAC Self-Assessment Audits during a COVID-19 outbreak, the home placed residents at potential risk for infection and prolonged outbreak.

Sources: Record review on November 23, 2023 – PHO IPAC Self-Assessment Audits; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; Interview with IPAC Coordinator.
[000690]

WRITTEN NOTIFICATION: IPAC

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any Standard issued by the Director with respect to infection prevention and control. Specifically, under section 6.1 of the Infection Prevention and Control Standard, revised 2023, the licensee did not make eye protection available and accessible to staff and did not ensure adequate access to eye protection when Additional Precautions were required.

A home area was declared in respiratory outbreak with multiple residents on Additional Precautions (Droplet).

There was signage posted at the entrance to resident's room directing staff to wear eye protection (goggles or face shield) within two meters of resident contact. Isolation cart outside a resident's room did not have eye protection.

All supply carts used to store personal protective equipment were checked by a registered staff acknowledged that none of the supply carts had eye protection and that staff should have been donning eye protection within two meters of residents. Upon checking the carts in the clean utility, it was noted that only one goggle was found.

PSWs working on a home area said that they did not have eye protection available to them on the supply carts since the beginning of the outbreak and that they were not wearing eye protection when providing care to residents.

Failure to wear the required PPE during an outbreak placed residents and staff at potential risk for transmitting and contracting infectious diseases.

Sources: Critical Incident report , observations and interview with PSW and RPN. [532].