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: January 25, 2024
Inspection Number: 2024-1117-0001
Inspection Type: Proactive Compliance Inspection
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.02.02 09:02:14 -05'00'

Additional Inspector(s)
Yami Salam (000688)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10 - 12, 15 - 19, and 22, 2024

The following intake(s) were inspected:

- Intake: #00105516 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Respond

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
Duty to respond
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to ensure that concerns identified by the Resident's Council were responded to within 10 days.

Rationale and Summary:

In December 2023, Resident Council held a meeting. The meeting minutes documented that two concerns were identified and that forms were completed and left with the ED. The meeting minutes did not explain what the concerns were.

The home's process for concerns raised at the Council meetings was to document the concerns and take them to the manager involved to resolve.

Neither the Director of Programs or the ED recalled any concerns received from the Residents' Council from the December 2023 meeting, and as such no response had been provided to the Council.

Sources: Resident Council meeting minutes December 2023, interview with ED #100 and Director of Programs. [659]

WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
Orientation
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and

neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training as mentioned in this subsection, of specific importance, the Resident's Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of a resident, the duty under section 28 to make mandatory reports, and infection prevention and control.

Rationale and Summary:
A Personal Support Worker's (PSW) first shift to perform their duties was in January 2024.

A review of their online training on Surge Learning indicated that the PSW had not completed their orientation training prior to working with residents.

The Executive Director (ED) stated that they expected that the PSW should have completed their online orientation training prior to their first shift, but they had not.

Failure of the licensee to ensure the PSW completed their orientation prior to

performing their duties poses gaps in care and services offered to those residing in the long-term care home and places residents at risk for harm.

Sources: PSW's Surge Learning training, interview with ED and staff. [000688]

WRITTEN NOTIFICATION: Retraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
Retraining
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining annually related to infection prevention and control.

Rationale and Summary:
A PSW was hired in December 2022, and completed IPAC training for orientation upon hire.

The PSW had not received annual retraining for infection prevention and control for the year 2023.

The ED stated that the staff member should have completed the IPAC component

of annual training on Surge Learning.

Sources: PSW's retraining records on Surge Learning, Interview with ED. [000688]

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that two residents were bathed by the method of their choice.

Rational and Summary:
A) A resident stated that they preferred to receive showers once a week.

Bathing records for the resident for a six week period between November and December 2023, did not show the resident had received a shower on their scheduled shower dates. There was no documentation of the missed showers being completed on other dates.

The Director of Resident Care (DRC) stated that there were no documentation of the

missed showers offered on other dates.

The resident was put at risk when they failed to receive regular showers in a consistent manner to meet their personal hygiene requirements.

Source: Resident's plan of care, documentation survey, progress notes, interview with resident and DRC . [000688]

B) A resident stated that their preferred choice of bathing was a bath, but they received showers since their admission.

The resident's bathing records for a five week period in November to December 2023, did not show the resident received a bath or shower on their scheduled dates. There was no documentation of the missed baths being completed on other dates.

The Executive Director of Nursing (EDON) stated that the resident should have had their plan of care updated to receive baths instead of showers as per their expressed wishes.

The resident was put at risk when they failed to receive regular baths as their preferred choice in a consistent manner to meet their personal hygiene requirements.

Source: Resident's plan of care, documentation survey, progress notes, interview with resident and EDON. [000688]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that procedures were implemented for cleaning and disinfecting of resident care equipment including mechanical lifts in between residents use.

Rational and Summary:
In January 2024, a mechanical lift that was used for a resident's transfer was not cleaned and disinfected after a resident use.

A PSW stated they were supposed to disinfect the mechanical lift after it was used for the resident, but they did not.

The Executive Director (ED) stated that staff were expected to disinfect the mechanical lifts between different residents.

Failure to clean and disinfect the mechanical lift in between residents exposed the resident to risk of possible infection.

Sources: Observation, review of manufacturer's specifications, Interview with the PSW, ED and other relevant staff. [000688]

WRITTEN NOTIFICATION: Continuous quality Improvement committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that the continuous quality improvement committee (CQI) included at least one employee of the licensee who has been hired as a personal support worker (PSW) or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

Rationale and Summary:
Attendance from CQI meeting agenda's for December 2022, July 2023 and January 2024 did not include a PSW as a committee member.

The ED acknowledged the home's CQI committee had not included a PSW as a committee member.

Failure to include the PSW as a CQI committee member limits information and input from front line staff into quality improvement initiatives at the home.

Sources: Continuous Quality improvement agendas December 2022, July 2023 and January 2024, interview with ED [659]

WRITTEN NOTIFICATION: Continuous quality improvement report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure the Residents' Council had received a copy of the Continuous Quality Improvement (CQI) report.

Rationale and Summary:
The meeting minutes for Resident Council and the Resident Council binder did not have any documentation to indicate the CQI report was shared during their meetings.

Two residents and the ED also stated they were unaware of whether the CQI report was shared with Resident council.

Not providing a copy of the CQI reports to the Residents' Council limits their ability to review the reports in detail and have input or make further recommendations for changes/improvements to the operations and/or services provided.

Sources: Residents' Council minutes 2023, Family Council minutes 2023, CQI minutes for 2022 - 2023, interviews with ED, Director of Programs and residents. [659]