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: August 22, 2024

Inspection Number: 2024-1117-0005

Inspection Type:
Critical Incident
Follow up

Licensee: peopleCare Communities Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7- 9, 13-16, and 19, 2024

The following intake(s) were inspected:

Intake: #00116290 - Follow-up #: 1 - O. Reg. 246/22 - s. 286 (5)
Intake: #00116291 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)
Intake: #00116292 - Follow-up #: 1 - FLTCA, 2021 - s. 27 (1) (a) (i)
Intake: #00116293 - Follow-up #: 1 - O. Reg. 246/22 - s. 105
Intake: #00116294 - Follow-up #: 1 - FLTCA, 2021 - s. 28 (1) 4.
Intake: #00114869 - related to medication administration.

Intake: #00116321 - related to falls prevention and management.
Intake: #00116451 - related to abuse.
Intake: #00124270 - related to staffing and training.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order ##004 from Inspection #2024-1117-0003 related to O. Reg. 246/22, s. 286 (5) inspected by Robert Spizzirri (705751)
Order ##005 from Inspection #2024-1117-0003 related to FLTCA, 2021, s. 24 (1) inspected by Robert Spizzirri (705751)
Order ##001 from Inspection #2024-1117-0003 related to FLTCA, 2021, s. 27 (1) (a) (i) inspected by Robert Spizzirri (705751)
Order ##002 from Inspection #2024-1117-0003 related to O. Reg. 246/22, s. 105 inspected by Robert Spizzirri (705751)
Order ##003 from Inspection #2024-1117-0003 related to FLTCA, 2021, s. 28 (1) 4. inspected by Robert Spizzirri (705751)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Trust Accounts

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 241 (10)
Trust accounts
s. 241 (10) The licensee shall have every trust account established under subsection (1) audited annually,
(a) by a public accountant licensed under the Public Accounting Act, 2004; or
(b) in the case of a municipal home or a joint home approved under Part VIII of the Act, by the municipal auditor who audits the books of account and ledgers of the home. O. Reg. 79/10, s. 241 (10).

The licensee failed to ensure that every trust account is audited annually.

The Director of Accounting and Financial Reporting said that an independent auditor, BDO Canada LLP, completes the annual audit of resident trust accounts.

The independent auditor will select a sample of residents who have a trust account, however, they do not audit every trust account. In 2021, they selected 34 residents out of approximately 174, who had a trust account.

When there are trust accounts not audited annually there is potential for discrepancies of either funds or processes to be missed.

Sources: Independent auditor's report, auditor's requests, and interview with the Director of Accounting and Financial Reporting,

[705751]

WRITTEN NOTIFICATION: Medication Administration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A resident was prescribed a specific amount of oxygen via nasal prongs for a health condition.

On a specific day the oxygen flow was set incorrectly and caused the resident to require medical attention.

On another day, the oxygen tank was empty while in use. The resident's health status declined and required medical attention.

The Director of Care (DNC) #114 acknowledged both of the incidents and stated for the last incident, the personal support worker (PSW) was aware of the oxygen need of the resident but transferred the resident with an empty oxygen tank.

Failure to ensure that a resident was provided with their oxygen needs jeopardized their health, safety or well-being, and placed them at risk of harm.

Sources: Critical incident report, progress notes, review of plan of care, resident's observations and interviews with staff and the DOC.
[532]

COMPLIANCE ORDER CO #001 Screening measures

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 81 (1)
Screening measures
s. 81 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a policy and procedure to ensure that all agency staff have completed a vulnerable safety check as required.

b) Educate all staff who have a role and/or responsibility within this policy and procedure. A record of this education must be kept in the home for review. The record must include the staff name, the education received, the date and their signature for completion.

c) When the policy and procedure is implemented complete an audit for all agency staff who are currently employed by the home, and, for all agency staff employed following 30 days of implementation. The audit must be recorded and kept in the

home for review. The audit must include the staff name, that a vulnerable sector check was received and reviewed, and actions taken if necessary.

Grounds
The license failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff.

O. Reg 246/22 s. 252 (1) applies where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.

As per O. Reg. 246/22 r. 252 (3), the police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The home used an agency, Home Instead, for one-to-one staff. There were no records of screening measures for these staff in the home. DRC #108 said that they entrusted the agency to screen staff, and that there was no process implemented at the time for the home to review this information.

DNC #108 asked Home Instead to provide relevant documents to screen three of their staff. It was discovered that all agency staff did not have a completed vulnerable sector check as required.

When the home does not ensure that vulnerable sector checks are completed as required, there is an increased risk of residents being abused and/or neglected.

Sources: Email communication, lack of records, interview with DRC #108 and other staff.

[705751]

This order must be complied with by September 27, 2024

COMPLIANCE ORDER CO #002 Training

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (1)
Training
s. 82 (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a policy and procedure to ensure that all agency staff have received orientation and additional training as required under s. 82 of the Act prior to performing their responsibilities.

b) Educate all staff who have a role and/or responsibility within this policy and procedure. A record of this education must be kept in the home for review. The record must include the staff name, the the education received, the date and their signature for completion.

c) When the policy and procedure is implemented complete an audit for all agency

staff who are currently employed by the home, and, for all agency staff employed following 30 days of implementation. The audit must be recorded and kept in the home for review. The audit must include the staff members name, requirements of orientation and training, it's completion, and actions taken if necessary.

Grounds
The licensee failed to ensure that all staff from Home Instead, providing one-to-one services, received training as required by this section.

A one-to-one staff said that they did not receive any training in the home. They said they only had one day of orientation which included shadowing PSWs providing care to the resident.

There were no records in the home that indicated any one-to-one staff from Home Instead received the required education in this section.

DRC #108 said that they entrust education to be provided by Home Instead. There was no process to ensure the education's content, and whether or not it had been provided.

When the licensee does not ensure staff have received the required orientation and training, there is risk of acts, regulations, policies and procedures not being followed and that the care being provided is not competent.

Sources
Email communication, lack of records, interview with agency staff, DRC #108 and other staff.

[705751]

This order must be complied with by September 27, 2024

COMPLIANCE ORDER CO #003 Qualifications of personal support workers

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 52 (1)
Qualifications of personal support workers
s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 246/22, s. 52 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a policy and procedure to ensure that all agency staff, hired as a Personal Support Worker (PSW) or to provide personal support services, regardless of title, are qualified.

b) Educate all staff who have a role and/or responsibility within this policy and procedure. A record of this education must be kept in the home for review. The record must include the staff name, the the education received, the date and their signature for completion.

c) When the policy and procedure is implemented complete an audit for all agency staff who are currently employed by the home, and, for all agency staff employed following 30 days of implementation. The audit must be recorded and kept in the home for review. The audit must include the staff members name, their designation, the review of their qualifications, and actions taken if necessary.

Grounds

The licensee failed to ensure agency one-to-one staff had successfully completed a personal support worker program, and that the proof of graduation issued by the education provider was provided to the licensee.

DRC #108 said that all one-to-one staff from Home Instead provide personal support services because they were personal support workers (PSW).

An agency one-to-one staff said they were directed by the home to provide personal support services to a resident. They were not a PSW.

DRC #108 said they had relied on Home Instead to ensure staff provided were qualified. They said that records were not requested or reviewed prior to being made aware during this inspection.

When the home does not ensure staff are qualified prior to providing personal support services, there is a risk of improper / incompetent care to be provided.

Sources:

Email communication, absence of employee records, interview with agency staff, DRC #108 and other staff.

[705751]

This order must be complied with by September 27, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.