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

Public Report

Report Issue Date: January 10, 2025

Inspection Number: 2024-1117-0007

Inspection Type:
Complaint
Critical Incident

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): January 6 - 10, 2025

The following intake(s) were inspected:

- Intake: #00129717 regarding an alleged abuse of a resident.
- Intake: #00132769 regarding an unwitnessed fall of a resident.
- Intake: #00133596 complaint regarding a fall of a resident.

The following intakes were completed in this inspection:

- Intake: #00130670 regarding an unwitnessed fall of a resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure that the home and resident equipment were kept clean and sanitary when equipment in a resident's shared bathroom environment were observed to be visibly soiled on multiple occasions.

Sources: Observations in January 2025, Interviews with PSW and IPAC Lead.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an incident involving improper or incompetent care of a resident was reported to the Director. A resident was improperly transferred which resulted in risk of injury. The incident of improper and/or incompetent care was not reported to the Director as required.

Sources: Home's investigation notes, Zero Lift and Transfer program, interviews with resident and DRC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident.

Sources: Resident's care plan and progress notes, Home's investigation notes and complaint response record, Home's Zero Lift and Transfer Program, Interviews with resident and DRC.