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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Public Report

Report Issue Date: July 31, 2025

Inspection Number: 2025-1117-0003

Inspection Type:
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 dates: July 25, and 28-30, 2025

The inspection occurred offsite on the following date: July 31, 2025

The following Critical Incident (CI) intake was inspected:

- Intake #00149878, related to falls prevention and management

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

A. A resident no longer needed a falls prevention strategy; however, their plan of care directed staff to provide this intervention.

On July 28, 2025, the resident's plan of care was revised, and this intervention was resolved.

Sources: Long-Term Care Homes (LTCH) Inspector's observations, a resident's clinical records, and an interview with staff.

B. A resident no longer needed to have Additional Precautions in place; however, signage for Additional Precautions was observed on the resident's room entrance.

On July 28, 2025, the resident's plan of care was revised to include the updated information.

Sources: LTCH Inspector's observation, a resident's clinical records, and an interview with staff.

Date Remedy Implemented: July 28, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. iii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
iii. names of staff members who responded or are responding to the incident.

The licensee has failed to ensure that the names of three staff members who responded to a resident's fall were included in the critical incident report.

On July 30, 2025, the critical incident report was amended to include the required information.

Sources: a critical incident report, a resident's clinical records, and interview with staff.

Date Remedy Implemented: July 30, 2025

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that two falls prevention interventions were provided to a resident as specified in their plan of care.

In accordance with O. Reg 246/22 s.11 (1) (b), the licensee is required to implement strategies to reduce or mitigate the risk of falls. Specifically, the home's Falls Prevention and Management policy directed staff to use the falls prevention interventions identified in the resident's plan of care.

On two separate occasions, a resident's falls prevention interventions were not provided as specified in their plan of care.

Sources: LTCH Inspector's observations, a resident's plan of care, the home's falls prevention and management policy and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident had an area of skin injury, they were assessed by the registered nursing staff using the home's wound evaluation tool.

Sources: a resident's clinical records, and an interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to ensure that a resident's pain was assessed as specified in the home's pain assessment policy.

In accordance with O. Reg 246/22 s.11 (1) (b), the licensee is required to implement communication and assessment methods for residents who are unable to

communicate their pain or who are cognitively impaired. Specifically, the home's pain assessment policy directed registered nursing staff to utilize a specific pain scale to assess pain for residents who were cognitively impaired.

Over approximately one-month period, on multiple occasions, a resident's pain was not assessed as specified in the home's pain policy.

Sources: a resident's clinical records, the home's pain assessment policy, and an interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when the initial pain management interventions were not effective, a resident's pain was assessed as specified in the home's pain assessment policy.

In accordance with O. Reg 246/22 s.11 (1) (b), the licensee is required to implement pain assessment procedures. Specifically, the home's pain assessment policy directed staff to complete a pain assessment in the resident's electronic record when initial intervention to relieve pain was not effective.

On two occasions, a resident's pain was not relieved by the initial pain management

interventions; however, pain assessments as specified in the home's policy were not completed as required.

Sources: a resident's clinical records, the home's pain assessment policy, the home's investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 ensure that the additional requirement under section 9.1 of the Infection Prevention and Control (IPAC) Standard issued by the Director was followed.

Specifically, the licensee has failed to ensure that the required Personal Protective Equipment (PPE) was used when Additional Precautions were in place. On one occasion, two staff did not wear the appropriate PPE as required.

Sources: LTCH's observation, a resident's plan of care, IPAC Standard (2023), Additional precautions signage, the home's Additional precautions policy, and interviews with staff.