Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, 31, Sep 2, 8, 9, 2011	2011_054133_0013	Complaint

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6

Long-Term Care Home/Foyer de soins de longue durée

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Service Manager, the designated lead for the recreation and social activities program, Registered Nurses, registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) conducted a walk-through of all resident home areas and common areas, reviewed the health care record of 3 residents, reviewed documentation related to the recreation and social activities program.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Critical Incident Response

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits sayants :

1. As it relates to s. 6(1)b: Three resident's plan of care related to recreational care do not include goals the care is intended to achieve.
2. .

As it relates to s. 6 (1)c: A resident's plan of care related to recreational care does not provide clear directions to staff and others who provide direct care to them. Their plan of care contains the following statements related to recreational care: "Regularly encourage client to attend activities (prn/prn)", "take client to activity room 5 min before program (prn/prn)", "staff to involve client in 1:1 visits with volunteer, or another client (prn/prn)" and "activity as tolerated (prn/prn)".

A second resident's plan of care related to recreational care does not provide clear directions to staff and others who provide direct care to them. Their plan of care contains statements related to recreational care that indicate staff are to continue to invite and encourage the resident to the variety of recreational programs offered.

A third resident's plan of care related to recreational care does not provide clear directions to staff and others who provide direct care to them. Their plan of care contains the following statement related to recreational care: "staff to engage client in short diversional activities, frequency = prn time=prn".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) 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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits sayants :

1. As it relates to s. 107 (1) 1: The licensee failed to inform the Director immediately of flooding in the home that occurred on June 28, 2011. On that evening there was a heavy downpour of rain and water emerged into the home by way of a drain behind the nursing station. The Environmental Services Manager indicated to the inspector that he estimates there was 1.5 inches of water on the floor around the nursing station and surrounding hallway, the medication room behind the nursing station and in a resident bedroom close to the nursing station. The Director of Care indicated to the inspector that the residents who reside in the affected bedroom were all resting in their beds when the flooding occurred. The residents remained in their beds while staff removed the flood water. That night the Environmental Services Manager removed the lower portion of the affected wall in the affected bedroom and ran fans for 16 hours to ventilate the wall cavity.

As it relates to s. 107 (4): The licensee failed to make a report in writing to the Director about flooding that occurred within the home on June 28, 2011.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the requirement to inform the Director immediately of critical incidents as described in LTCHA, 2007, S.O. 2007, c.8, s.107(1) and, within 10 days of becoming aware of such incidents, to make a report in writing to the Director that contains all required information, to be implemented voluntarily.

Issued on this 9th day of September, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs