Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2015	2015_346133_0012	O-001175-14, O-001401-14 AND O-001656-15	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.

This inspection was conducted on the following date(s): April 20th - 23rd, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Associate Director of Care, the Environmental Services Manager, the Director of Food Services, registered and non registered nursing staff

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 79 (3) (e) in that the licensee has failed to ensure that the long term care home's procedure for initiating complaints to the licensee is posted in the home.

On April 20th, 2015, Inspector #133 asked the Associate Director of Care (ADOC) to provide a copy of the licensee's written complaints procedure. The ADOC brought the inspector a copy of an excerpt from the handbook that is given to residents upon admission, the "procedure for reporting concerns" section. The ADOC confirmed that the written procedure appears only in the resident handbook, and is not posted in the home.

The licensee has a history of non compliance in this area. As a result of the Resident Quality Inspection conducted in 2012, #2012_039126_0001, a written notification was issued as a result of the failure to post certain required information, including the procedure for initiating complaints to the the licensee [s. 79. (3) (e)]

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 that the long term care home's procedure for initiating complaints to the licensee is posted in the home, in a conspicuous and easily accessible location, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (a) in that the licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. This is specifically related to privacy curtains in some identified resident bedrooms.

On April 20th and 21st, 2015, Inspector #133 observed the following in the identified bedrooms.

#28 a) - The privacy curtain between bed 3 and the neighbouring bed had a large, circular, dark red stain on the middle of the last panel (closest to the wall).

#28 b) - The privacy curtain at bed 1 was dirty with spots of dried yellow matter, between panel 1 and 2, and had some red stains on the last panel.

#27 a) - The privacy curtain at bed 1 was dirty with areas of dried white matter near the base, midway along the first panel and some areas of dried brown matter. The second panel was dirty with large areas of dried light colored matter and spots of dried red/brown matter.

#27 b) - The privacy curtain between bed 2 and 3 was stained orange, along the lower area of the 1st panel, and was also dirty with some spots of dried orange/brown matter in the same area.

#34 – The privacy curtain around the bed next to the window, on the right hand side of the room (when facing in to the room from the hallway) was dirty with areas of dried cream colored matter.

#26 – The privacy curtain was dirty with two areas of dried brown matter, in the lower corner portion of the curtain.

#24 – The privacy curtain was dirty with spots of dried light colored matter, along the lower portion of curtain.

#25 – The privacy curtain was extensively stained, pink, along the outer edge of the curtain.

#23 – The privacy curtain was dirty with one distinct area of dried light colored matter and some smaller spots of dried red/brown matter.

#14 – The privacy curtain between bed 1 and 2 was dirty with smudges of dark brown matter, on the side facing bed 2, at the 2nd panel. The privacy curtain was also extensively stained and soiled, light brown to orange in color, between panel 2 and 3.

#17 – The side of the privacy curtain that faces the bed next to the window was very dirty with many small spots of dried orange/brown matter and clear matter, throughout the 1st panel.

#18 – The side of the privacy curtain facing the bed next to the window was dirty with a large oblong shaped area of dried light colored matter. The side of the privacy curtain facing the other bed was dirty with small areas of dried dark matter, near the outer edge.

#19 – The privacy curtain at bed 1 was dirty with areas of dried white matter, inside of the 1st panel.

#22 –The 1st panel of the privacy curtain between bed 1 and 2 was extensively stained a light pink color.

Late afternoon of April 21st, 2015, Inspector #133 showed the home's Environmental Services Manager (ESM) some of the dirty privacy curtains, in some west hall resident bedrooms. The ESM committed to auditing privacy curtains in resident bedrooms throughout the home the next morning. When the inspector arrived to the home, on April 22nd, 2015, the process of laundering all privacy curtains that required it had begun. By lunchtime, freshly laundered west hall bedroom privacy curtains were being rehung by the ESM. The inspector observed the privacy curtains to be clean and stain free.

The ESM told the inspector that all privacy curtains are laundered at minimum once a year. In addition, the ESM explained that housekeeping staff are expected to check the privacy curtains and window curtains every day, and to have them laundered if they are not clean. The ESM pointed out that on the housekeeping routine checklist, which housekeeping staff fill out every day for every resident bedroom, there is a section titled "ensure curtains are free of debris". Upon further discussion, it was speculated that housekeeping staff may understand this section to refer to window curtains only. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c.8, s. 20 (1) in that the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

This is specifically related to training for staff that is required by the policy, that is not being delivered.

On April 20th, 2015, the Associate Director of Care (ADOC) provided the licensee's written policy to promote zero tolerance of abuse and neglect of residents to the inspector (Abuse or Neglect Policy, revision date of January 10, 2014).

In accordance with O. Reg. 79/10, s. 96 (e) (i), the licensee's written policy to promote zero tolerance of abuse and neglect must identify the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for residents care. The licensee's written policy does state that upon orientation, staff will be trained in this area. The licensee's written policy does not reflect the need for retraining of staff in this area, and this non-compliance has been captured elsewhere within the inspection report (see Written Notification #4).

In accordance with O. Reg. 79/10, s. 96 (e)(ii), the licensee's written policy to promote zero tolerance of abuse and neglect must identify the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations. The licensee's written policy does state that upon

orientation, staff will be trained in this area. The licensee's written policy does not reflect the need for retraining of staff in this area, and this non-compliance has been captured elsewhere within the inspection report (see Written Notification #4).

Although the licensee's written policy to promote zero tolerance of abuse and neglect of residents states that new staff will receive orientation training in the two areas mentioned above, orientation training in these areas is not being provided to staff. The ADOC informed the inspector that the orientation training and annual retraining that staff get related to resident abuse is the Surge Learning Inc. course titled "Resident Abuse and Neglect". On April 22, 2015, the inspector viewed the course, and found that it did not cover the two required areas. It is acknowledged that the course does review an example of neglect and an example of verbal abuse, that is also possibly an example of financial abuse. These examples do not however represent training in either of the two required areas. Following review of the Surge Learning Inc. course, the inspector had a debriefing with the ADOC, and asked if there was anything else that the ADOC would like the inspector to review related to training in these areas. The ADOC indicated there was nothing else to be reviewed. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 96 (b) in that the licensee has failed to ensure that that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

On April 20th, 2015, the Associate Director of Care provided the licensee's written policy to promote zero tolerance of abuse and neglect of residents to the inspector (Abuse or Neglect Policy, revision date of January 10, 2014). As required, the policy contains the standardized definitions of emotional, financial, physical and sexual abuse as per O. Reg. 79/10, s. 2. These definitions differentiate abuse of a resident by another resident, and abuse of a resident by anyone other than a resident. Physical abuse, for example, means the use of physical force by anyone other than a resident that causes injury or pain, or, the use of physical force by a resident that causes physical injury to another resident.

The licensee's written policy to promote zero tolerance of abuse and neglect of residents does not contain procedures or interventions to deal with a resident who has abused or neglected or allegedly abused or neglected another resident. It is acknowledged that the policy does speak to how the home would deal with other persons, such as staff or visitors, who have abused or neglected or allegedly abused or neglected a resident. [s. 96. (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 96 (e) in that the licensee has failed to ensure that that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identifies the specified retraining requirements for all staff.

On April 20th, 2015, the Associate Director of Care provided the licensee's written policy to promote zero tolerance of abuse and neglect of residents to the inspector (Abuse or Neglect Policy, revision date of January 10, 2014). The policy explicitly states that upon orientation, staff will receive training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for residents care. The policy also explicitly states that upon orientation, staff will receive training on situations that may lead to abuse and neglect and how to avoid such situations. The policy does not identify that staff require retraining in these two areas. [s. 96. (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 100. in that the licensee has failed to ensure that the written complaints procedure required under section 21 of the Act incorporates the requirements set out in section 101 of O. Reg. 79/10.

Section 21 of the Act states that every licensee of a long term care home shall ensure there are written procedures that comply with the regulations (O. Reg. 79/10) for initiating complaints to the licensee and for how the licensee deals with complaints.

On April 20th, 2015, Inspector #133 asked the Associate Director of Care (ADOC) to provide a copy of the licensee's written complaints procedure. The ADOC brought the inspector a copy of an excerpt from the handbook that is given to residents upon admission ("procedure for reporting concerns"), and a copy of an excerpt from the employees handbook ("employee complaint procedure"). The excerpt from the employees handbook was reviewed and found not to pertain to the requirements set out in section 101 of O. Reg. 79/10. The "procedure for reporting concerns", from the resident handbook, was reviewed and was found to contain some, but not all of the requirements set out in section 101 of O. Reg. 79/10.

The written complaints procedure does not fully comply with O. Reg. 79/10, s 101 (1) 1. in that it does not explicitly state that if the complaint alleges harm or risk of harm to one or more residents, the complaint investigation will begin immediately.

The written complaints procedure does not fully comply with O. Reg. 79/10, s. 101 (1) 2. in that it does not specify that acknowledgement of receipt of such a complaint will be provided within 10 business days. As well, it is not specified that for such complaints, a follow up response shall be provided as soon as possible.

The written complaints procedure does not comply with O. Reg. 79/10, s. 101 (1) 3. in

that it does not provide details about the response that the licensee is required to make.

The written complaint procedure does not comply with O. Reg. 79/10, s. 101 (2) in that it does not speak to the required documented complaint record that the licensee must keep in the home.

The written complaint procedure does not comply with O. Reg. 79/10, s. 101 (3) in that it does not speak to the required review and analysis of the required documented complaint record.

The written complaint procedure does not comply with O. Reg. 79/10, s. 101 (4) in that it does not speak to the exceptions related to the required documented complaint record when verbal complaints are resolved within 24 hours of having been received.

Inspector #133 had follow up discussion about the written complaints procedure with the Administrator and the Associate Director of Care. The Administrator indicated there was another version of a written complaints procedure, but that it was in draft form, and was not ready for review by the inspector. [s. 100.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 216 in that the licensee has failed to ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act.

In accordance with LTCHA, 2007, S.O. 2007, c. 8, s. 76 (2), the licensee shall ensure

that, prior to performing their responsibilities, all staff at the home are provided with orientation training in the areas described within this provision.

For the purposes of section 76 (4) of the Act, all staff who receive orientation training in the areas mentioned in section 76 (2) are to receive retraining annually in the mentioned areas, as described by O. Reg. 79/10, s. 219 (1). Staff that were employed at the home at the time that the Act came into force, in 2010, are to be included in the required annual retraining program, as described by O. Reg. 79/10, s. 220.

For the purposes of section 76 (2) 9 of the Act, all staff of the home are to be provided with orientation training and annual training in infection prevention and control, as described by O. Reg. 79/10, s. 219 (4). This includes hand hygiene, modes of infection transmission, cleaning and disinfection practices; and use of personal protective equipment.

For the purposes of section 76 (2) 11, all staff of the home are to be provided orientation training and annual retraining in additional areas, as described by O. Reg. 79/10, s. 218, which includes the licensee's written procedures for handling complaints and the role of staff in dealing with complaints.

Over the course of the inspection, April 20 – 23, 2015, Inspector #133 reviewed components of the training and orientation program for staff with the home's Associate Director of Care, who identified herself as the lead for the training and orientation program.

At the time of the inspection, the training and orientation program did not include the licensee's written procedures for handling complaints and the role of staff in dealing with complaints.

At the time of the inspection, the training and orientation program did not include orientation training for new staff in the areas of modes of infection transmission; and cleaning and disinfection practices.

At the time of the inspection, the training and orientation program was not implemented to ensure that new staff receive orientation training, prior to performing their responsibilities, in the areas of hand hygiene and use of personal protective equipment. The orientation training records for the four most recently hired Personal Support Workers (PSWs), staff # 100 - #103, was audited by the inspector in collaboration with

the ADOC. Only one of the four PSWs, staff # S100, had completed the required training in the two areas mentioned above prior to performing their responsibilities. Staff #101, hired in December 2014, had not completed training in these two areas at the time of the inspection. Staff # 102, hired in February 2015, completed training in these two areas after having worked ten shifts during which they were performing their responsibilities. Staff #103, hired in March 2015 had partially completed training in the area of hand hygiene prior to performing their responsibilities, and had not completed training on the use of personal protective equipment at the time of the inspection. [s. 216. (1)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.