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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 16, 2016 | 2016_450138_0025 | 013495-16 | Resident Quality Inspection |

### 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

PAULA MACDONALD (138), HEATH HEFFERNAN (622)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): August 9, 10, 11, 12, and 15, 2016.**

**Critical Incident Inspection 021039-16 relating to a resident injury was conducted as part of this Resident Quality Inspection.**

**During the course of the inspection, the inspector(s) spoke with the President of the Residents' Council and the alternate, the Owner/Administrator, the Director of Resident Care, the Registered Dietitian, the Director of Environmental Services, the Director of Activation, Volunteer Co-ordinator, the Director of Food Services, the Scheduling/Ward Clerk, the Financial Clerk, registered practical nurses (RPNs), registered nurses (RNs), personal support workers (PSWs), a dietary aide, residents, and family members. Contact was also made with a member of the Family Council.**

**The inspectors also reviewed resident health care records, reviewed a Critical Incident Report, observed residential areas of the home, observed a medication administration pass, and reviewed minutes for the Residents' Council.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.**

**Findings/Faits saillants :**

1. The licensee failed to comply with section 13. of the regulation in that the licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On August 9, 2016, Inspector #138 observed that the privacy curtains in shared rooms 13-4,14-2, and 17-1 were insufficient to provide total privacy for each of the residents. On August 12, 2016, the Inspector toured these rooms with the Director of Environmental Services. The Director of Environmental Services stated that he would arrange to have the adequate privacy curtains installed.

This issue was previously identified in August 2015 on Resident Quality Inspection #2015_285126_0030 with a Written Notification (WN). [s. 13.]

***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 to ensure each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to comply with section 36. of the regulation in that the licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The home submitted a Critical Incident Report outlining that resident #007 suffered an injury after staff #100 attempted to transfer the resident while seated in a wheelchair.

Inspector #138 spoke with resident #007 regarding the incident. Resident #007 stated that s/he was sitting in a wheelchair when a staff member came up from behind and started to push the resident's wheelchair without any warning. Resident #007 stated that s/he did not hear the staff member come up from behind and also that s/he was not expecting nor was s/he prepared for anyone to push the wheelchair. The resident stated that s/he yelled out immediately to stop from being pushed any further but that s/he had suffered an injury as a result of the wheelchair being pushed.

The Inspector reviewed the health card record for resident #007 and noted that the resident experienced pain after the incident. Pain management was provided and a diagnostic test was ordered. The Director of Resident Care stated that the diagnostic test was inconclusive and the resident was sent to the hospital for further examination. The health care record shows that the hospital diagnosed the resident with a specific injury.

The Inspector spoke with the RPN #101 and the Director of Resident Care regarding this incident. RPN #101 stated that Resident #007 will self propel in a wheelchair. The Director of Resident Care also stated that Resident #007 will self propel in a wheelchair but further added that staff will communicate to the resident when they are going to push the resident's wheelchair so that the resident can be safely positioned for the transfer. The Director of Resident Care stated that she investigated the incident and determined that staff #100 did not properly prepare resident #007 prior to transferring the resident in his/her wheelchair.

(021039-16) [s. 36.]

***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 to ensure that staff use proper techniques when transferring residents in wheelchairs, to be implemented voluntarily.***

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**Issued on this 16th day of August, 2016**

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

**Original report signed by the inspector.**