Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 31, 2020	2020_831211_0006	014925-20, 015333-20, 015699-20	Complaint

Licensee/Titulaire de permis

Hilltop Manor Nursing Home Limited
1005 St. Lawrence Street P.O. Box 430 MERRICKVILLE ON K0G 1N0

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

Hilltop Manor Nursing Home (Merrickville)
1005 St Lawrence Street P.O. Box 430 MERRICKVILLE ON K0G 1N0

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

JOELLE TAILLEFER (211), MANON NIGHBOR (755)

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): July 29, 30, 31, 2020 and August 4, 5, 6, 7, 10, 11, 12, 2020.

The following complaints intakes: Logs #014925-20, #015333-20, #015699-20 inspected were related to nursing and personal support services, housekeeping issues, shortage of staff, Infection prevention and control program, pest control, air temperature, cooling requirements, safe and secure home's environments, neglect and abuse prevention.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Director of Environmental Services, Director of Activation, Assistant of Director of Care (ADOC), Registered Dietician (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario employee (BSO), Personal Support Workers (PSWs), Financial Clerk, Environmental Services employees, Dietary Aide, Fire Chief, Arjo Canada Sale Representatives and residents.

The inspectors conducted a tour of the home, observed care and meal services, reviewed residents' health care records, staffing plan, schedules, manufacture's instruction, housekeeping routine checklist, preventative pest control service records, and reviewed literature relating to hot weather-related illness programs, hydration, infection prevention and control.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Snack Observation

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

- **5 WN(s)**
- **2 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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Review of resident #028's care plan from an identified date, indicated that the resident was at risk for fall.

Review of resident #028's progress notes written by RN #125 on an identified date, indicated that the resident tripped over an item placed in an identified area and sustained an injury.

In an interview with PSWs #112, #126 and RN #125 revealed that the items placed on an identified area were a tripping hazard. Furthermore, PSW #126 witnessed resident #028 tripped on the item and sustained a fall on an identified date.

The licensee has failed to ensure that the home was safe and secure environment for resident #028 when an item was placed on an identified area. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use assistive aids in the home in accordance with manufacturers' instructions.

On an identified date, during an interview with staff # 112, they reported that the assistive aids being used for transfers should have the "identified support items" inserted in them.

On an identified date, the specified assistive aids was observed without the identified support items inserted in the assistive aids' pocket for residents #005 and also found in resident #016's bedroom as well has a third one hanging on the wall beside the medication room across from the Director of Cares office.

During an interview on an identified date with staff #118, they confirmed that they were not aware of the identified support items were required or where they were kept. Staff #118 said they were using the assistive aids without the support items inserted in the identified pocket of the assistive aids.

On two identified dates, two different Sales Representatives with ARJO Canada do not recommend the use of the assistive aids for transfers without the identified support items and stated to be important as they protect the head, neck and shoulder of the residents during transfers.

The licensee has failed to ensure that staff insert the identified support items in the assistive aids for transfers in the home in accordance with manufacturers' instructions. [s. 23.]

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 staff use assistive aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: 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 ensure that the home is kept clean and sanitary.

On an identified date, the Ministry of Long-Term Care home received a complaint indicating that the home was filthy and there was little cleaning happening in the facility.

Eight days later, Inspector #211 and the Director of Environmental Services observed clumps of dust on the floor behind an identified structure fixed on the wall at the end of an identified hallway.

Seven days later, Inspector #211 observed several identified resident's bedroom areas to be dusty and dirty. Inspector #755 observed other multiple rooms that were in the same condition with dirt stains, clumps of dust and black debris, especially in the corners of the rooms, behind beds, and chairs and some just along the walls.

The next day, Inspector #211 observed some of those resident's bedrooms areas were still dusty and dirty. [s. 15. (2) (a)]

2. On an identified date at a specific time, Inspector #211 observed clumps of dust behind an identified fixture toward the wall. RPN #122 stated that the area behind the identified fixture had never been cleaned. The Environmental Services #123 didn't know when this area was cleaned.

The licensee has failed to ensure that residents' bedroom areas and behind an identified fixture's area were sanitary. [s. 15. (2) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home shall protect residents from verbal abuse by a

staff member.

As per O reg. 79/10. S. 2. verbal abuse means any form of verbal communication of a threatening or intimidating nature of any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

A complaint was received by an identified individual, reporting that an identified staff has been verbally abusive to residents and specifically referred to resident #009.

This alleged verbal abuse has been validated by three identified individuals and resident #009.

During the course of the inspection, the identified individual, said that an identified staff is “always screaming, especially to one resident,” referring to resident #009. The identified individual stated they reported to the Director of Care with a formal letter on an identified date. The letter indicated that they had grave concern with the identified staff's behavior toward the residents. It was also included that residents are agitated when the identified staff was on duty. Furthermore, the letter indicated that the identified staff's behavior is having a negative impact on residents”.

In an interview with another specified individual on an identified date, said that resident #009 will ask them for an identified items because they don’t want to be yelled at by the identified staff. The identified individual reported that some of the residents were scared of the identified staff.

During the course of the inspection, resident #009 shared that they didn’t feel safe when the identified staff was in and reported that the identified staff had yelled at them numerous times, when they requested the identified items between a specific times.

Resident #009 reported that when they asked the identified staff, when their care would be provided, the identified staff responded with an angrily, raised voice. Resident #009 explained that they had said to an identified individual: “Isn’t the identified staff scary?” Resident #009 has stated that they are in tears when the identified staff was on.

On an identified date, the identified staff admitted "I do raise my voice, I do”. “I know, I shouldn’t”. The identified Staff said "staff get stressed, I get stressed and residents get stressed.

The licensee of a long-term care home shall protect residents from verbal abuse by the identified staff. [s. 19. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when 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;
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On an identified date, the Ministry of Long-Term Care received a complaint from an identified individual that reported multiple concerns in the home.

During the course of the inspection, three identified individuals reported that between specific months, they confirmed they have verbally informed the Director of Care of their suspicion of abuse and neglect. Furthermore, between two other specific months, a total of three letters were written and shared with the Director of Care, reporting their

suspicion of abuse and neglect.

During an interview with resident #009 on an identified date, the resident reported being scared when the identified staff raises their voice. Resident #009 reports this happens especially between a specific times when they ask the identified staff for a specific item. Resident #009 stated being in tears and upset when the identified staff is on. Resident #009 said they spoke to the Director of Care, two weeks ago, two days in a row.

On an identified date, during an interview, the identified individual stated that the identified staff is “always screaming and yelling, especially to one resident” and referred to resident #009. The identified staff “stood there yelling at resident #009 for several minutes instead of given them the item, I timed them”. Furthermore, the identified individual stated they gave the Director of Care a letter with their concerns with the identified staff having a “negative impact on residents”, “constant screaming at residents” and when the identified staff is on, residents are agitated”.

Another identified individual, reported during an interview on an identified date, that resident #009 will ask another identified individual instead of the identified staff for their specific items, because they do not want to be yelled at by the identified staff. The identified individual reported that some of the resident are scared of the identified staff. The identified individual also stated that with resident #035, whom as specified behaviors, the identified staff told the resident “in a grumpy tone, like scary tone”; you know you’re the one, making this noise, you need to turn around and go the other way. The identified individual said that resident #035 “looked scarred and doesn’t understand”. Furthermore the identified individual stated that “this has been going on for a long time”.

On an identified date, during the course of an interview, another identified individual stated that on a specific date, they reported to the identified staff that resident # 007 was in pain. The identified staff responded that they had already received Tylenol and didn’t have time and would leave a note for a colleague to deal with it, tomorrow. Furthermore, the identified individual stated that they gave the Director of Care a letter on a specific date with their suspicions of neglect.

The licensee has failed to ensure when identified individuals has reasonable grounds to suspect that an identified staff verbally abused residents #009 and #035 and neglected resident #007, should immediately report the suspicion and the information upon which it is based to the director. [s. 24. (1)]

Issued on this 1st day of September, 2020

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

Original report signed by the inspector.