

**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
Feb 19, 2021	2021_565647_0004	025748-20, 025867-20	Complaint

Licensee/Titulaire de permis

Hillcrest Village Inc.
255 Russell Street Midland ON L4R 5L6

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

Hillcrest Village Care Centre
255 Russell Street Midland ON L4R 5L6

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

JENNIFER BROWN (647), TRACY MUCHMAKER (690)

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): February 8 - 11, 2021.

The following intakes were completed in this Complaint inspection:

-one intake, related to staff to resident abuse, and one intake, related to care concerns.

Critical Incident System inspection (CIS) 2020_565647_0005 was completed concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Facilitators (RCF), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Recreation/Program therapists, and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed Infection Control and Prevention (IPAC) practices, observed medication administration, observed dining and snack service, observed staff to resident interactions, resident to resident interactions, and the provisions of care, reviewed internal documents, and policies and procedures.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program, was evaluated and updated at least annually in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices, specifically to ensure there was signage posted on or near the entrance door of affected residents that indicated the resident was on additional precautions.

In accordance with Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, homes are required to have signage specific to the type(s) of additional precautions posted. A sign that lists the required precautions was to be posted at the entrance to the resident's room or bed space.

During the inspection, Inspector #647 observed that four rooms, had a cart that contained additional Personal Protective Equipment (PPE) outside the resident's door, however, no sign was present to indicate what the required PPE would be.

A Personal Support Worker (PSW) indicated they would not be aware of what PPE they would be required to don to enter the residents room and a Registered Nurse (RN) indicated all doors with affected resident's were required to have a sign to ensure all staff were aware of the additional precautions they must take to care for the affected resident.

Sources: Inspector #647's observations, Interviews with the Director of Care (DOC) and other staff, and Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012. [s. 229. (2) (d)]

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 participate in the implementation of the Infection Prevention and Control (IPAC) program, specifically to ensure there is signage posted on or near the entrance door of affected residents to indicate, that the resident is on additional precautions, to be implemented voluntarily.

Issued on this 23rd day of February, 2021

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

Original report signed by the inspector.