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
Feb 24, 2022	2022_745690_0005	020575-21	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

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 14-18, 2022.

The following intake was inspected upon during this Complaint inspection:

-One intake, which was a complaint related to care concerns of several residents.

A Critical Incident System (CIS) inspection #2022_745690_0006 was conducted concurrently with this inspection.

Inspector #735285 observed this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Facilitator, Housekeeping Manager, Infection Prevention and Control (IPAC) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, 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, staff to resident interactions, reviewed health records, internal documents, and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Falls Prevention and Management policies and procedures included in the required Falls Prevention Program were complied with, for a resident.

O. Reg. 79/10, s. 48 (1) 1, requires an organized program for Falls Prevention to reduce the incidence of falls and the risk of injury, and O. Reg. 79/10, s. 49 (1) requires that the program includes strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention Assessment and Management Policy and Procedure".

The home's Falls Prevention Policy indicated that when a resident had fallen, a post fall huddle would be conducted to collect as much detail about the fall as possible and to make necessary referrals and update the interventions to prevent further falls.

A resident had a fall, and a post fall assessment conducted after the fall, indicated that there were no interventions put in place to prevent a recurrence. The plan of care did not identify any interventions or strategies put in place after the fall to prevent further falls or injuries from falls. The resident had another fall four days later and sustained a minor injury. The resident's care plan was updated to include additional interventions after the second fall.

A Personal Support Worker (PSW), and a Registered Practical Nurse (RPN), stated that they were not aware of any interventions put in place to prevent further falls, until after the second fall. The Director of Care (DOC) verified that upon review of the resident's

plan of care, there were no interventions or strategies put in place until after the second fall occurred.

Sources: A resident's post fall assessments and care plan, the home's policy titled, "Falls Prevention Assessment and Management Policy and Procedure", last revised November 19, 2021, interviews with a PSW, an RPN, and the DOC. [s. 8. (1)]

2. The licensee has failed to ensure that the home's medication management policy was complied with.

Ontario Regulation 79/10 s. 114 (2) requires that the licensee has written policies and protocols for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's policy titled "Handling Medication-Drug Destruction and Disposal", which was part of the of the home's medication management system.

The home's policy indicated that unused or damaged doses of monitored medications (e.g dose dropped on the floor), was to be destroyed during the shift by nursing staff and another staff member.

During an observation of a medication pass, an RPN, dropped a tablet on the floor, and the Inspector observed the RPN pick the tablet up off the floor, place in the medication cup. Registered staff, and the DOC, stated that if a medication was to drop on the floor, the medication should be destroyed, replaced with another tablet from the resident's supply and the pharmacy provider was to be notified.

Sources: Observations of a medication pass, the home's policy titled, "Handling of Medication-Drug Destruction and Disposal", last revised November 2020, interviews with Registered staff, and the DOC. [s. 8. (1) (b)]

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's Fall Prevention Policy and Medication Management Policy is complied with, to be implemented voluntarily.

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:

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 fire, unplanned evacuation or intake of evacuees.
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 disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance, or a communicable disease as defined in the Health Protection and Promotion Act.

A Critical Incident System (CIS) report for a disease outbreak was submitted to the Director, for a COVID-19 outbreak. There was a call placed to the Ministry of Long Term Care (MLTC) INFOLINE - LTC Homes After Hours reporting system to notify the Director of the outbreak a day after the outbreak was declared. The DOC confirmed that the home did not immediately report the disease outbreak.

Sources: A CIS report, and Info-line report, interview with the DOC. [s. 107. (1)]

Issued on this 25th day of February, 2022

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

Original report signed by the inspector.