



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2016	2016_258519_0004	004323-16	Complaint

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

peopleCare Hilltop Manor Cambridge
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 16, 2016

This Complaint inspection was done while the team was in the home for the annual RQI. This report was done outside of the RQI report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Executive Director of Resident Care, the Director of Resident Quality Outcomes, a Registered Practical Nurse, a Personal Support Worker, and the family of the Resident.

The Inspector reviewed the electronic file and the investigation notes.

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Reporting and Complaints**

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>Legendé</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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights
Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that they promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On a specified date, Resident # 001 was left unattended and requiring care.

According to Resident # 001's plan of care the Resident required extensive assistance to one staff assistance; depending on how the Resident was that particular day.

Upon interview with a Registered Staff on a specified date, it was stated that in report the message was relayed that this Resident had been left requiring care and assistance. The resident was watched for signs of emotional distress. The Registered Staff stated the Resident was stable during their shift.

Upon interview with the Director of Resident Quality Outcomes on a specified date, it was stated that the family were notified. The Registered Staff stated that she instructed a Personal Support Worker (PSW) to attend to the Resident. The PSW could not remember being instructed to do this care.

The licensee failed to ensure that they promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity after Resident # 001 was left requiring care and assistance for a lengthy period of time. [s. 3. (1) 1.]

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 promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.



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Issued on this 8th day of June, 2016

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

Original report signed by the inspector.