Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 6, 2024	
Inspection Number: 2024-1117-0002	
Inspection Type: Complaint	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge	
Lead Inspector Janis Shkilnyk (706119)	**Inspector Digital Signature** Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2024.03.07 08:46:46 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27-29, 2024

The following intake(s) were inspected:

- Intake: #00104290 - complaint related to visitation and Residents' Bill of Rights
- Intake: #00106730 - complaint related to visitation and Residents' Bill of Rights

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care conference

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

Care conference

s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held annually to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker.

Rationale and Summary:

An annual care conference was to have occurred for a resident. No care conference documentation was found in the resident's clinical record.

The Director of Resident Care stated that the resident had not had a annual conference completed as required.

Failure to complete a annual care conference may impact opportunities for the multidisciplinary care team, resident and family to review and participate in a residents plan of care.

Sources:

Review of a resident's clinical record, interview with Director of Resident Care

[706119]

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 6.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
a) Ensure all members of the management team are provided education in relation to the role and responsibilities of a substitute decision maker for a resident, specifically limiting visitation of a resident.
b) Document the education including the date, format and staff attending the training, including the staff member who provided the education.
c) Review and revise the home's Ethical Decision Support Case Summary Form to include time frames for completion and implementation of plans recommended by the ethics committee of the home to facilitate the prompt management of ethical

issues identified.
d) Ensure that all members of the home's ethics committee and management team are educated on the revision and document the education including the date, format and staff attending the training, including the staff member who provided the training.

Grounds

The licensee has failed to ensure that a resident received visitors of their choice and was able to consult in private with any person without interference.

A complaint was made by a family member regarding visitation being denied.

The Long-Term Care Home denied visitation by a family member to a resident, due to the home's concerns during their visits in the home.

A family member had not been allowed to visit the resident for approximately ten months. The home's investigation, and the Ethical Summary, concluded that a plan should be implemented to allow visiting. No such plan was implemented.

The Ministry of Long-term care conducted an inspection into the same matter and the home was issued a written notification of noncompliance for the Residents' Bill of Rights related to visitation. The home continued to pause the family member from visiting the home.

Ten months after the complainant was told they could no longer visit; an action plan was developed by the home. The plan allowed the family member to visit but was never implemented.

The home's Bioethicist summarized further recommendations of the ethics committee documenting the home should facilitate planned visits as there was a

change in health status of another family member. The home did not take action on this recommendation.

Staff stated that the resident had requested to see their family member on several occasions while visitation was paused. On one occasion the resident was upset when told the family member could not visit them.

The acting Executive Director (ED) stated that the expectations of the home were to follow the recommendations of the home's ethics committee, The ED would have expected the family member be able to visit with a plan and was unaware why this had not taken place.

The resident's right to receive visitors of their choice for a ten-month period was not respected or promoted when the home did not implement a plan for visitation between the resident and family member.

Sources:

Investigation report, Ethical Summary- Family Access to Resident vs Staff Safety report, Action Plan, email from Bioethicist, interview with acting Executive Director, and staff

[706119]

This order must be complied with by April 15, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.