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
Jan 25, 2022	2022_973573_0001	000400-22	Proactive Compliance Inspection

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

ANANDRAJ NATARAJAN (573), HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 10 - 14, 17, 18 and 19, 2022

During the course of the inspection, the inspector(s) spoke with the residents, President of the Residents' Council, Administrative Assistant, Housekeeping staff, Dietary Aides, Personal Support Workers, Personal Support Assistant, Registered Practical Nurses, Registered Nurses, Pharmacist, Director of Environmental Services, Director of Food Services, Programs Director, Assistant Director of Care, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed relevant documents, including residents' health care records, selected policies and procedures and Residents' Council meeting minutes.

The inspector(s) observed the residents, resident home areas, the provision of care to the resident and observed staff to resident interactions. In addition, the inspectors observed meal service, Infection Prevention and Control and medication administration practices.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

5 WN(s)
4 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the doors leading into the laundry room and kitchen were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home, on two separate occasions the inspector observed that the laundry room door which led to industrial laundry equipment and cleaning supplies could be pushed open. The laundry area was not being supervised by staff at the time of each observation. On the same day, the inspector observed that the kitchen door was not locked which allowed access to the kitchen supplies, equipment, and utensils. The kitchen area was not being supervised by staff at the time.

Sources: observation of non-residential doors, interview with the Director of Food Services, laundry staff and other staff. [s. 9. (1) 2.]

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 doors leading into the laundry room and kitchen were kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs, and goods provided at the home.

The Quality Improvement & Required Programs LTCH Licensee Confirmation Checklist was reviewed by the inspector. The Director of Care who signed the checklist indicated that a survey had not been taken, at least annually, of the residents and their families to measure their satisfaction with the home and the care, services programs and goods provided in home. During the interview, the Director of Care confirmed that since July 2020, a survey had not been conducted.

Sources: The Quality Improvement & Required Programs LTCH Licensee Confirmation Checklist, interview with the Director of Care and other staff interviews. [s. 85. (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 ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs, and goods provided at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the interview, the Director of Care stated that quarterly meetings with the Medical Director, the Administrator, the Director of Care and the pharmacy service provider to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system had not taken place since April 2020.

Sources: interview with the Director of Care and the Pharmacist. [s. 115. (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 ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Care (DOC) and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

A review of LTCH report of annual evaluation of required programs 2020, indicated that changes and improvements were identified for a few programs. During the interview, the Director of Activities confirmed that all the changes /improvements identified through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents had not been communicated to the Residents' Council in the past year.

Sources: LTCH report of annual evaluation of required programs 2020, interview with the Director of Activities and other staff interviews. [s. 228. 4. iii.]

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 improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the plan of care indicated that a resident was to be transferred with two-person assistance.

The PSW documentation indicated that on eleven separate dates, staff had documented that they transferred the resident using one staff. During the interview, the PSW stated that they believed the resident required one staff assistance for transfers, when they transferred the resident independently on a day in 2022.

Sources: the resident's plan of care, interview with the PSW and other staff. [s. 6. (7)]

Issued on this 27th day of January, 2022

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

Original report signed by the inspector.