Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2015	2014_195166_0033	O-001279-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

CAROLINE TOMPKINS (166), BARBARA ROBINSON (572), LYNDA BROWN (111), MATTHEW STICCA (553), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 8-13, December 15-18, 2014

During the course of this Resident Quality Inspection, Critical Incidents, Log # O-000833-14 ,001213-14, 001415-14, 001080-14, 001018-14, 001009-14, 000967-14, 001290-14, 000939-14, 000772-14, 000766-14, 000939-14, 000772-14 and 000766-14 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Family, President of the Residents' Council, President of the Family Council, Administrator, Director of Care, RAI Coordinator, Environmental Manager, Physiotherapist, Administrative Assistant, Occupational Therapist, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), members of the Behaviourial Support Team(BSO).
The inspectors also observed interactions between staff and residents during the provision of care, dining and snack services, administration of medication, resident programs and activities, toured resident rooms and common areas, reviewed clinical health records and the licensee's policies: Abuse, Neglect-Prevention, Reporting and Investigation, Minimizing Restraints, Falls Prevention and Management Program, Medication and Family and Resident Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **1 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	Legendé 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that for each resident, demonstrating responsive behaviour's of wandering and elopement, strategies were developed and implemented to respond to these behaviours where possible, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Log # O-0000772 & O 001009(Resident #45)
Two critical incident reports(CIR) were received reporting a missing resident (less than 3 hours).
The information in the first CIR reports that Resident #45 was witnessed by a staff member in the park behind the home. The resident was returned to the home and had sustained some bruising but denied any pain. The Resident's Power of Attorney(POA) was notified and a wander guard bracelet was applied.
The second CIR reports that a staff member called the home to report Resident #45 was found outside of the home and was being returned. There were no injuries to the resident.
The actions taken to prevent a re-occurrence included:
-monitoring resident "more closely throughout remainder of the shift" and environmental services to be advised that roam alert system not activated when resident exited the facility.

Review of the progress notes for Resident #45 (6 month time frame) indicated:
Resident #45 had two reported incidents of elopement. A wander guard bracelet was applied after the first elopement incident.

During the reviewed 6 month time frame, Resident #45 had 11 episodes of exit seeking, where the resident was found off the unit and in the lobby or just outside the main entrance doors. The wander guard roam alert did not trigger during 3 of the exit seeking incidents and the resident had removed the wander guard in 2 incidents.
- Care plan for Resident #45 indicated the resident demonstrated wandering responsive behaviour. Interventions included:
-allow resident to wander in safe and secure environment,
-to wear wander guard bracelet at all times on right wrist,
-current picture available on file at reception desk,
-reminisce about the past with resident,
-if wanders, offer diversional activity, provide directional cues (pictures, ribbon, name on door),
-keep substitutes for lost items (purse, keys, glasses),
-place familiar objects/furniture in surroundings,
-ensure resident is comfortable (not constipated, hunger or in pain),
-encourage ambulation/exercise, implement relaxation techniques (music/TV) as a diversion,
-check resident regularly for wandering to ensure resident is safe.

Review of RAI-MDS assessments indicated behavioural symptoms of wandering occurred daily for last 7 days but no rap summary note was completed for the triggered RAP. Interview of RAI Coordinator stated "the summary notes should have been completed".

The strategies identified to manage the responsive behaviour of wandering and elopement included use of a wander guard bracelet. The interventions do not indicate how often staff are to check placement of bracelet. The care plan indicated a strategy of check resident regularly for wandering to ensure the resident is safe was not clear as to whom and when this was to occur.
Review of the DOS completed for Resident #45 indicated the DOS was completed on an identified date for 8 hours. There was no other documented evidence of monitoring checks for Resident #45.

Log # O-000939-14 (Resident #46):

A critical incident report (CIR) was received for a missing resident less than 3 hours incident.
The CIR reports that Resident #46 was noted missing when the resident was not in the

dining room for supper.
The Administrator (while driving), observed the resident walking down the road away from the home and stopped to question the resident (but did not see a wander guard). The Administrator returned to the home and questioned the reception if the resident was on the wandering residents' list and determined the resident was not on the wandering residents' list.
A code yellow was initiated when it was determined that Resident #46 was missing. The resident was found by police and returned to the home with no injury. The resident had no prior incidents of elopement.

Review of the progress notes for Resident #46 (6 month time frame) indicated:
Resident #46 had 1 reported incident of elopement. The Resident was returned to the home with no injuries. A wander guard bracelet was applied to the resident and the resident was placed on a DOS monitoring tool for every 30 minute checks.

During the reviewed 6 month time frame, Resident #46 had 26 documented episodes of exit seeking behaviours, where the resident was found packing personal belongings, verbalizing leaving the home, attempting to exit the unit via the elevator and in the lobby . The resident had removed the wander guard in 1 incident.
Three care conferences were held with family in attendance:
The first care conference held with family discussed the resident’s wandering and exit seeking behaviours and the possibility of the resident’s admission to the secure unit. The family refused.
A second care conference held with family and discussion regarding placing resident on "safely home program", encouraging resident to attend programs in the home and possible 1:1 visits with volunteers. Resident medications were reviewed by physician, changes made to antidepressants and initiation of DOS assessment tool every 30 minute check.
A third care conference held with family re: wandering risk still present but more controlled at present. Resident continues to wear wander guard and staff to check daily that bracelet is in place.
Review of the care plan for Resident #46 indicated the resident.
-required supervision when on/off the unit and cannot exit the home without supervision. The resident demonstrated the responsive behaviour of unsafe wandering due to cognitive impairment, poor decision making, and making statements that they are leaving. Interventions included apply wander guard to wrist, and every 30 minute checks on DOS tool.

Review of the progress notes indicated the resident continued to be a wandering and elopement risk as the resident was frequently wandering off the unit and exiting the building. The resident demonstrated the following triggers: frequently packing up belongings, telling staff looking for family, and changing into day clothes during the night.

The following strategies were used:
-application of wander guard & redirection,
-contacting family over the phone to speak with resident,
-providing puzzles and towel folding, DOS tool for every 30 minute checks, -administration of medications,
-closing the unit doors,
-1:1 monitoring,
These strategies were not identified in the responsive behaviour care plan, were not consistently utilized and the resident was frequently found by reception on the main floor prior to staff being aware the resident was missing from the unit.
The care plan does not provide all identified triggers or strategies to be used to manage the responsive behaviour of wandering and elopement.
The care plan does not indicate that the resident had eloped from the home on more than one occasion.
The interventions do not indicate where the wander guard is to be applied, or how often staff are to check placement of bracelet, or how long DOS tool to be utilized. Review of the DOS tool indicated the resident was documented as monitored every 30 minutes for 2 days

Log # O-000967 & 001018 (Resident #47):

Two critical incident reports(CIR) were received reporting a missing resident (less than 3 hours).
The first CIR indicated that Resident #47 was found in a store. The store contacted the home regarding the missing resident; staff initiated a code yellow and called the police. The resident was returned to the home by staff with no injuries. The POA was notified.
The CIR indicated a fire drill was occurring in the home at 18:30 and staff reported last observing the resident at supper at approximately 18:10. The resident had no prior incidents of elopement but had a history of wandering on and off the unit and vocalizing to staff the resident was going home. The resident was wearing a wander guard bracelet at the time of the elopement.
The second CIR reports that a pedestrian found Resident #47 wandering down the street with a walker with the resident name on the walker and reported it to reception. Resident

#47 was wearing the wander guard bracelet at the time of the elopement but the alarm did not activate. The POA was notified. The actions taken by the home included notifying the Environmental Manager and an urgent call was placed to the supplier to reassess the system and resident placed on q 1 hour monitoring. A care conference was also to be scheduled with family to discuss relocating resident to a secure unit.

Review of the progress notes for Resident #47 for a 6 month time frame indicated: Resident #47 had two reported incidents of elopement.
Review of the progress notes for Resident #47 (6 month time frame) indicated: Resident #47 had 3 documented incidents of elopement, 2 incidents were reported and had wandered off the unit on 4 separate occasions (one attempt to exit from the back door).
The Resident was returned to the home with no injuries. A wander guard bracelet was applied to the resident and the resident was placed on an hourly monitoring.
During the reviewed 6 month time frame, Resident #47 had 4 documented episodes of exit seeking behaviours. The wander guard bracelet did not alarm as the system is not set up for the back doors.
Review of the RAI-MDS for Resident# 47 indicated under behavioural symptoms: wandering occurred 1-3 days in last 7 days. There were no summary notes completed.
Interview of the RAI-Coordinator stated "there are no summary notes completed for this triggered RAP but there should have been notes completed". Review of the point of care system did not indicate the resident was monitored every hour.
The care plan for Resident #47 indicated the resident demonstrated responsive behaviours of wandering related to dementia, history of elopement and making statements that the resident is leaving.
Interventions included:
- provide diversional activities,
-encourage involvement in activities,
-monitor behaviour episodes and attempt to determine underlying causes,
-document behaviour and potential causes (resident may be looking for a person, place or object from the past),
-reminisce with the resident about the past (photo albums, old magazines),
-determine if wandering is to relieve stress/tension and allow opportunity to pace safely,
-allow resident to wander if environment is safe and secure,
-apply roam alert bracelet and check resident's whereabouts for safety every hour when in building.

The strategies identified to manage the responsive behaviour of wandering and

elopement included use of a wander guard bracelet and there was no documented evidence the resident was monitored hourly. The care plan indicated a strategy of "check resident regularly for wandering to ensure the resident is safe" was not clear as to who and when this was to occur, and there was no indication of other strategies utilized or other actions taken (use of reception, wandering checklist at front desk) when the wander guard bracelet was noted to be ineffective to ensure the security of the resident. [s. 53. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Log O-001415-14
The licensee has failed to comply with LTCH 2007, s. 3(1), whereby the licensee did not ensure that the resident's right to participate in decision making was fully respected and promoted.
A critical incident(CIR) was received indicating that Resident#39 refused to have a tub bath and became angry and combative when approached to bathe. Staff #119 reported this information to Registered staff #123 and left the unit with a plan to re-approach the resident later. When Staff #119 returned to the unit, the staff observed that Resident #39 was upset and noted the resident had some bruising.

Review of Resident #39's plan related to personal hygiene directs staff to:
- Provide two persons to assist with bathing.
- Provide medication as ordered one hour prior to bath.
- Do not offer assistance before resident attempts activity on their own
- Allow resident to choose sequence of daily events.
- Involve resident in planning daily schedule.

Review of the documentation in the critical incident report, the progress notes, the licensee's investigation and interview with the Administrator indicated Resident #39 had refused a bath, became angry, combative, struck out at staff and hit the tub and mechanical lift with their hands causing bruising and that Registered Staff #123 had directed Personal Support staff to bathe Resident #39 without the resident's consent. [s. 3. (1) 9.]

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 Resident #39 and all other residents have the right to have his or her participation in decision making respected, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Log # O-001290-14

A critical incident report(CIR) was received indicating that during the transfer of Resident #43 from chair to bed,the resident sustained a laceration and was sent to the hospital for further treatment.

Review of Resident #43 plan of care indicated the resident required extensive assistance by two staff to assist with all transfers.

Interview with Occupational Therapist (OT) staff #140 and MDS-RAI coordinator staff #148 indicated that when a resident requires extensive assistance by two staff, the transfer is a two persons side by side assist.

Interview with PSW #125 and review of the licensee's investigation of the incident including statements from PSWs #125 and #145 indicted that during the transfer from wheelchair to bed PSW #125 assisted the resident from the front while PSW #145 was behind guiding the resident.

During an interview with the OT staff #140 indicated that PSWs #125 and #145 did not transfer Resident #43 side by side as required. [s. 36.]

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 use safe transferring and positioning or techniques when assisting residents., to be implemented voluntarily.

WN #4: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Log # O-000967-14 & O-001018-14:
The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

Review of the progress notes for Resident #45 indicated on identified date, the resident was returned to the home by 2 citizens, who found the resident walking by themselves down the street behind Hillsdale Terraces. The resident had no injury.

This incident of elopement was not reported to the Director. [s. 107. (3)]

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 Director is informed within 1 business day after an occurrence of a resident who is missing for less than 3 hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During the initial tour of the home the following was noted:
-on all three floors (2nd, 3rd, 4th) there are 4 home areas each with a tub/shower room. The shower areas in each area had wood paneling walls and each of these walls had large areas of scuffing where the finish has been worn off.
-on Primrose Path(4th) the flooring in the tub room was worn out in several areas;
-on Golden Pond(3rd) and Pine Ridge Place(2nd) there are large stains noted on the floor in the tub areas.
-on Primrose Path, Strawberry Fields and Pine Ridge Place, home areas, a large section of the blue seal around the tub edge had come off exposing a sharp metal edge; the maintenance log books on each of the units did not indicate repairs required to tubs related to blue plastic seal coming off.

Interview of the Environmental Manger indicated he was aware that the wooden paneled walls in the shower rooms were heavily scarred with the finish worn off from staff scraping them in wheel chairs and lifts. The Environmental Manager indicated the wood paneled walls in the "tub rooms" were refinished approximately 2 years ago but did not have any plans at the moment to refinish the shower room walls.
The Environmental Manager indicated that he was aware of the floors in the tub rooms having large stained areas and indicated that the supplier has attempted several different products and methods to remove them but have been unsuccessful and that the floors were old and would need to be replaced.
The Environmental manager was not aware of the blue plastic seals coming off the bath tubs in specified units.
The following day, the Environmental Manager indicated all the tubs with blue plastic seals coming off had been repaired.

Interview of the Administrator indicated that he was aware that the shower room wooden walls and tub room floors are in poor state of repair and has plans in the capital budget for next year to have those areas repaired. Review of the capital budget indicted "tub room renovations" 2015-2017. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.
During stage 1 of the Resident Quality Inspection the following was observed:
-On Blueberry unit, Resident #31's call bell was activated by Inspector #572, no indicator light or sound was audible.
-On Maple Grove unit, Resident #3,4 and 8's call bells were activated by Inspector #166, no sound was audible.
-on Primrose Lane unit, Resident #25 & #26's call bells were activated by Inspector #111, no sound was audible.
Interview with 2 RPNs on Primrose Lane and interview with PSWs and 2 RPNs on Maple Grove indicated the call bells can be heard at the nursing station where the enunciator panel is located but indicated that when they are in a hallway away from the panel, the call bells are not audible.
Interview with the The Administrator indicated he was aware of the issue with call bells not being audible throughout the home and has it in the 2015 capital budget to replace the system.
Interview of the Environmental Manager indicated the communication system in the home had been recently inspected by the service agency responsible for the system but the service agency did not test the volume in each unit to ensure the call bell can be heard throughout the areas.
The Environmental Manager indicated that service agency would be returning to the home "to check volume levels on each unit".
During this inspection, the indicator lights and non-functioning call bells for Resident #3 & #31 were repaired. [s. 17. (1) (g)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

December 8, 2014, during the dining observation, Inspector #572, observed a medication cart to be unlocked and unattended, residents and visitors were observed to be wandering in the area of the unattended and unlocked medication cart .
December 15, 2014 Inspector #553 observed a medication cart outside of residents' rooms. The cart was unattended and unlocked. The inspector was able to access the drawers of the medication cart. [s. 129. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. Log O-000833-14
The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.
A critical incident (CIR)was received indicating that a medication error had occurred during medication administration.
Review of the CIR, the licensee investigation and interview with the Director of Care indicated that staff #136 realized during medication administration for the last 2 residents, they had administered Resident #49's medications to Resident #50.
Resident #50 was transferred and admitted to the hospital for further assessment and monitoring. [s. 131. (1)]

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Log No. / Registre no:	O-001279-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 22, 2015
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	HILLSDALE ESTATES 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Dickin

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies are developed to respond to responsive behaviours of wandering and elopement exhibited by Resident #45, #46 & #47 and any other resident exhibiting these behaviours.
The licensee will further ensure that actions taken to respond to the needs of Resident #45, #46 & #47 include: assessments, reassessments, interventions and the residents' responses to the intervention are documented.
The home's plan must include:
- how and when the home will seek appropriate support if implemented strategies provided prove to be ineffective,
- processes for monitoring that planned interventions for responding to responsive behaviours are implemented by staff and that the effect of the intervention is documented.
- a process for reassessment, monitoring and re-evaluation of best care strategies.
- provide education to all nursing staff specific to care planning and documentation
relating to resident responsive behaviours of wandering and elopement.
- develop or implement a process to monitor that documentation includes: identification of the responsive behaviour observed, triggers if any are identified, action taken by the staff, and the response of the resident.

This plan must be submitted in writing to MOHLTC, Attention: Lynda Brown, email
Lynda.Brown2@ontario.ca on or before January 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, of wandering and elopement, that strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to responds to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Log # O-0000772 & O 001009(Resident #45)
Two critical incident reports(CIR) were received reporting a missing resident (less than 3 hours).
The information in the first CIR reports that Resident #45 was witnessed by a

staff member in the park behind the home. The resident was returned to the home and had sustained some bruising but denied any pain. The Resident's Power of Attorney(POA) was notified and a wander guard bracelet was applied. The second CIR reports that a staff member called the home to report Resident #45 was found outside of the home and was being returned. There were no injuries to the resident.
The actions taken to prevent a re-occurrence included:
-monitoring resident "more closely throughout remainder of the shift" and environmental services to be advised that roam alert system not activated when resident exited the facility.

Review of the progress notes for Resident #45 (6 month time frame) indicated: Resident #45 had two reported incidents of elopement. A wander guard bracelet was applied after the first elopement incident.
During the reviewed 6 month time frame, Resident #45 had 11 episodes of exit seeking, where the resident was found off the unit and in the lobby or just outside the main entrance doors. The wander guard roam alert did not trigger during 3 of the exit seeking incidents and the resident had removed the wander guard in 2 incidents.
- Care plan for Resident #45 indicated the resident demonstrated wandering responsive behaviour. Interventions included:
-allow resident to wander in safe and secure environment,
-to wear wander guard bracelet at all times on right wrist,
-current picture available on file at reception desk,
-reminisce about the past with resident,
-if wanders, offer diversional activity, provide directional cues (pictures, ribbon, name on door),
-keep substitutes for lost items (purse, keys, glasses),
-place familiar objects/furniture in surroundings,
-ensure resident is comfortable (not constipated, hunger or in pain),
-encourage ambulation/exercise, implement relaxation techniques (music/TV) as a diversion,
-check resident regularly for wandering to ensure resident is safe.

Review of RAI-MDS assessments indicated behavioural symptoms of wandering occurred daily for last 7 days but no rap summary note was completed for the triggered RAP. Interview of RAI Coordinator stated "the summary notes should have been completed".

The strategies identified to manage the responsive behaviour of wandering and elopement included use of a wander guard bracelet. The interventions do not indicate how often staff are to check placement of bracelet. The care plan indicated a strategy of check resident regularly for wandering to ensure the resident is safe was not clear as to whom and when this was to occur.
Review of the DOS completed for Resident #45 indicated the DOS was completed on an identified date for 8 hours. There was no other documented evidence of monitoring checks for Resident #45.

Log # O-000939-14 (Resident #46):

A critical incident report (CIR) was received for a missing resident less than 3 hours incident.
The CIR reports that Resident #46 was noted missing when the resident was not in the dining room for supper.
The Administrator (while driving), observed the resident walking down the road away from the home and stopped to question the resident (but did not see a wander guard). The Administrator returned to the home and questioned the reception if the resident was on the wandering residents' list and determined the resident was not on the wandering residents' list.
A code yellow was initiated when it was determined that Resident #46 was missing.
The resident was found by police and returned to the home with no injury. The resident had no prior incidents of elopement.

Review of the progress notes for Resident #46 (6 month time frame) indicated: Resident #46 had 1 reported incident of elopement. The Resident was returned to the home with no injuries. A wander guard bracelet was applied to the resident and the resident was placed on a DOS monitoring tool for every 30 minute checks.

During the reviewed 6 month time frame, Resident #46 had 26 documented episodes of exit seeking behaviours, where the resident was found packing personal belongings, verbalizing leaving the home, attempting to exit the unit via the elevator and in the lobby . The resident had removed the wander guard in 1 incident.
Three care conferences were held with family in attendance:
The first care conference held with family discussed the resident's wandering and exit seeking behaviours and the possibility of the resident's admission to the

secure unit. The family refused.
A second care conference held with family and discussion regarding placing resident on "safely home program", encouraging resident to attend programs in the home and possible 1:1 visits with volunteers. Resident medications were reviewed by physician, changes made to antidepressants and initiation of DOS assessment tool every 30 minute check.
A third care conference held with family re: wandering risk still present but more controlled at present. Resident continues to wear wander guard and staff to check daily that bracelet is in place.
Review of the care plan for Resident #46 indicated the resident.
-required supervision when on/off the unit and cannot exit the home without supervision. The resident demonstrated the responsive behaviour of unsafe wandering due to cognitive impairment, poor decision making, and making statements that they are leaving. Interventions included apply wander guard to wrist, and every 30 minute checks on DOS tool.

Review of the progress notes indicated the resident continued to be a wandering and elopement risk as the resident was frequently wandering off the unit and exiting the building. The resident demonstrated the following triggers: frequently packing up belongings, telling staff looking for family, and changing into day clothes during the night.
The following strategies were used:
-application of wander guard & redirection,
-contacting family over the phone to speak with resident,
-providing puzzles and towel folding, DOS tool for every 30 minute checks, -administration of medications,
-closing the unit doors,
-1:1 monitoring,
These strategies were not identified in the responsive behaviour care plan, were not consistently utilized and the resident was frequently found by reception on the main floor prior to staff being aware the resident was missing from the unit.
The care plan does not provide all identified triggers or strategies to be used to manage the responsive behaviour of wandering and elopement.
The care plan does not indicate that the resident had eloped from the home on more than one occasion.
The interventions do not indicate where the wander guard is to be applied, or how often staff are to check placement of bracelet, or how long DOS tool to be utilized. Review of the DOS tool indicated the resident was documented as monitored every 30 minutes for 2 days

Log # O-000967 & 001018 (Resident #47):

Two critical incident reports(CIR) were received reporting a missing resident (less than 3 hours).
The first CIR indicated that Resident #47 was found in a store. The store contacted the home regarding the missing resident; staff initiated a code yellow and called the police. The resident was returned to the home by staff with no injuries. The POA was notified. The CIR indicated a fire drill was occurring in the home at 18:30 and staff reported last observing the resident at supper at approximately 18:10. The resident had no prior incidents of elopement but had a history of wandering on and off the unit and vocalizing to staff the resident was going home. The resident was wearing a wander guard bracelet at the time of the elopement.
The second CIR reports that a pedestrian found Resident #47 wandering down the street with a walker with the resident name on the walker and reported it to reception. Resident #47 was wearing the wander guard bracelet at the time of the elopement but the alarm did not activate. The POA was notified. The actions taken by the home included notifying the Environmental Manager and an urgent call was placed to the supplier to reassess the system and resident placed on q 1 hour monitoring. A care conference was also to be scheduled with family to discuss relocating resident to a secure unit.

Review of the progress notes for Resident #47 for a 6 month time frame indicated:
Resident #47 had two reported incidents of elopement.
Review of the progress notes for Resident #47 (6 month time frame) indicated:
Resident #47 had 3 documented incidents of elopement, 2 incidents were reported and had wandered off the unit on 4 separate occasions (one attempt to exit from the back door).
The Resident was returned to the home with no injuries. A wander guard bracelet was applied to the resident and the resident was placed on an hourly monitoring.
During the reviewed 6 month time frame, Resident #47 had 4 documented episodes of exit seeking behaviours. The wander guard bracelet did not alarm as the system is not set up for the back doors.
Review of the RAI-MDS for Resident# 47 indicated under behavioural symptoms: wandering occurred 1-3 days in last 7 days. There were no summary notes completed. Interview of the RAI-Coordinator stated "there are no summary

notes completed for this triggered RAP but there should have been notes completed". Review of the point of care system did not indicate the resident was monitored every hour.
The care plan for Resident #47 indicated the resident demonstrated responsive behaviours of wandering related to dementia, history of elopement and making statements that the resident is leaving.
Interventions included:
- provide diversional activities,
-encourage involvement in activities,
-monitor behaviour episodes and attempt to determine underlying causes,
-document behaviour and potential causes (resident may be looking for a person, place or object from the past),
-reminisce with the resident about the past (photo albums, old magazines),
-determine if wandering is to relieve stress/tension and allow opportunity to pace safely,
-allow resident to wander if environment is safe and secure,
-apply roam alert bracelet and check resident's whereabouts for safety every hour when in building.

The strategies identified to manage the responsive behaviour of wandering and elopement included use of a wander guard bracelet and there was no documented evidence the resident was monitored hourly. The care plan indicated a strategy of "check resident regularly for wandering to ensure the resident is safe" was not clear as to who and when this was to occur, and there was no indication of other strategies utilized or other actions taken (use of reception, wandering checklist at front desk) when the wander guard bracelet was noted to be ineffective to ensure the security of the resident. [s. 53. (4) (a)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROLINE TOMPKINS

Service Area Office /
Bureau régional de services : Ottawa Service Area Office