



**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**

**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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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Aug 2, 2016	2016_389601_0016	014374-16, 015311-16, 015468-16, 023882-15, 018553-16	Follow up

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### **Licensee/Titulaire de permis**

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

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

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

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

KARYN WOOD (601), BAIYE OROCK (624)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): July 20, 21, 22 and 25, 2016.**

**The following logs were inspected during the follow up inspection:**

**Follow up log #014374-16 regarding steps were not taken to minimize the risk of altercation between residents.**

**Log(s) #015311-16, #015468-16, #023882-15, #018553-16 critical incidents were submitted by the home regarding allegations of resident to resident altercations.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinators (RCC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), members of the Behavioural Support Team (BSO), family member and residents.**

**The inspectors also toured the home, observed interaction between staff and residents during the provision of care, reviewed clinical health records.**

**The following Inspection Protocols were used during this inspection:  
Reporting and Complaints  
Responsive Behaviours**

**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)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**

**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**



REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	CO #001	2016_389601_0008		601

### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**



**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Related to log #015468-16:

On an identified date and time, RN #105 witnessed resident #010 hit resident #011's on an identified area causing a reddened area.

On the following day approximately sixteen hours following the incident between resident #010 and #011, RCC #104 submitted a critical incident to the Ministry of Health and Long Term Care regarding allegations of resident to resident abuse that resulted in an injury to resident #011's identified area.

During an interview, the DOC indicated the Director had not been immediately notified related to the allegations of resident to resident abuse. A Critical Incident was submitted the following day approximately sixteen hours following the altercation between resident #010 and #011. [s. 24. (1)]



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***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 a person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.***

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Issued on this 3rd day of August, 2016

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

**Original report signed by the inspector.**