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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 31, 2017	2017_598570_0001	035428-16	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

SAMI JAROUR (570), CAROLINE TOMPKINS (166), KARYN WOOD (601), MEGAN MACPHAIL (551)

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): January 9-13 and January 16-20, 2017

The following logs were inspected during the Resident Quality Inspection (RQI):

- Critical incident (log #022373-16) related to improper care care of a resident;
- Critical incident (log #001028-17) related to alleged resident to resident sexual abuse;
- Critical incident (log #030199-16) related to unaccounted controlled substance;
- Critical incident (log #031637-16) related to a fall incident resulted in fractured hip;

- Critical incident (log #031664-16) related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Administrator, Managers of Nursing Practice, Resident Care Coordinators (RCC), Administrative Assistant, RAI-MDS Coordinator, RAI-MDS Coordinator back-up, the Dietitian, Infection Control Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), members of the Behavioural Support Team (BSO), Scheduling Clerk, Recreation staff, President of the Resident Council and Family Council, family members and residents.

Also during the course of the inspection, the inspector(s) toured the home, observed interactions between staff and residents during the provision of care, dining and snack services, administration of medication, reviewed clinical health records and the licensee's applicable policies, family and resident council minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #050's plan of care was revised when the resident's care needs change and care set out in the plan was no longer necessary.

Related to Log 001028-17

On a specified date, the Ministry of Health and Long-Term Care (MOHLTC) after hours pager was contacted to report an allegation of resident to resident sexual abuse. Critical Incident Report (CIR) was submitted to the Director on the following day.

The CIR documentation indicated that on a specified date, RN #108 was sitting at the nurses' station across from resident #050 and resident #051 when the RN observed resident #050 rubbing resident #051's body part.
RN #108 immediately intervened and moved resident #051 away from resident #050. Resident #051 was assessed, no injuries and no post incident effects were observed.

Plan of care for resident #050 in effect at time of incident identified that resident #050 had interventions in place related to inappropriate sexual behaviour which was directed toward staff, not residents.

Review of plan of care in effect after the incident, related to inappropriate sexual behaviour identified that interventions put in place to provide supervision for resident #050 to protect the rights and safety of other residents.

Review of clinical documentation and interview with RN, RPN, Recreation staff, BSO staff and PSWs indicated that resident #050 had not displayed any inappropriate sexual behaviour towards other residents since the reported incident of a specified date and interventions identified on the plan of care were no longer necessary.

Therefore resident #050's plan of care has not been revised to reflect resident #050 present behavioural status and interventions in the plan have not been reviewed or changed to determine if the plan is necessary. [s. 6. (10) (b)]

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 plan of care for resident #050 is revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Related to Log #031664-16:

On an identified date, the Ministry of Health and Long-Term Care (MOHLTC) after hours pager was contacted to report an allegation of staff to resident abuse/neglect, under LTCHA, s. 24 (1). Critical Incident Report (CIR) was submitted to the Director three days later.

According to the CIR, resident #044 reported to PSW #128 that PSW #129 did not provide the resident with an evening nourishment, refused to assist the resident with personal care and put the resident to bed too early.

According to the home’s investigation file, resident #044 informed PSW #128 of the concerns related to PSW #129 in the morning of an identified date. Resident #044 initially told the PSW that the resident was thirsty because the resident had not had anything to drink since the evening the night before, and that PSW #129 put the resident to bed at the PSW's discretion.

One day following the incident, PSW #128 reported resident #044’s care concerns to the Manager of Nursing Practice #131 who began an immediate investigation and notified the Director under the LTCHA.

According to the home’s policy titled Abuse and Neglect – Prevention, Reporting & Investigation (ADM-01-03-05) all staff, volunteers, contractors and affiliated personnel must immediately report any alleged suspected or witnessed incidents of abuse or neglect to the appropriate supervisor on duty.

In an interview with the Manager of Nursing Practice #131 on January 19, 2017 indicated that PSW #128 should have gone to a registered staff member immediately after resident #044 reported the concerns to the PSW. [s. 20. (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 all staff including PSW staff comply with the licensee's policy to promote zero tolerance of abuse and neglect of residents in relation to reporting of alleged abuse and or neglect incidents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with section 101(4) of the Act in that it failed to comply with the conditions to which the licensee is subject to as it relates to RAI-MDS assessments for residents.

The "Long-Term Care Home Service Accountability Agreement– Multi Homes April 1, 2013 to March 31, 2016" is the current service accountability agreement between the Regional Municipality of Durham, who is the licensee for Hillsdale Estates, and the Central East Local Health Integration Network. This agreement is required as set out by the Local Health System Integration Act, 2006 and is a condition that the licensee of Hillsdale Estates is subject to. Inspector #551 obtained a copy of this accountability service agreement and noted that section 8.1(c) outlines Hillsdale Estates obligation to conduct quarterly assessments of residents as required by RAI MDS, and that RAI MDS is to be used correctly to produce accurate assessments of the residents.

According to “Resident Assessment Instrument RAI-MDS 2.0 User Manual” dated February 2012, used by long term care homes, the RAI-MDS assessment includes the following components: RAI-MDS 2.0 Assessment, Decision Making, Care Plan Development, Care Plan Implementation and Evaluation.

The algorithm designed to support Decision Making, which is used by this home, is called Resident Assessment Protocols (RAPs). When key items in the RAI-MDS assessment indicate a risk, the issue if flagged, and a RAP is triggered. The RAP consists of an in-depth evaluation of the problem. Following the completion of the actual assessment, the designated staff member has seven days to complete the triggered RAP.

RAI-MDS information from the home is submitted to CCIM. For this inspection, the assessment date range for MDS information was from December 13, 2015 to November 11, 2016.

The health care records of the following residents, which included the RAI-MDS quarterly assessment were reviewed:

Resident #038:

On an identified date, the RAI-MDS assessment, resident #038 was coded as resisting care 1-3 days in the last 7 days. In the following assessment on an identified date, the resident was coded as resisting care 4-6 days in the last 7 days, but less than daily. A Behaviour Symptoms RAP was triggered, and the trigger since the last assessment was “adjusted”.

A review of resident #038’s health care record indicated that a RAP related to Behavior Symptoms was not completed. In the assessment of an identified date, 7 RAPs for various care areas were triggered, and of the 7 triggered RAPs, only 1 for Psychosocial Well-Being was written by a recreation staff member.

Resident #037:

In the RAI-MDS assessment on an identified date, resident #037 was coded as not resisting care in the past 7 days. In the following assessment on an identified date, the resident was coded as resisting care 1-3 days in the last 7 days. A Behaviour Symptoms RAP was triggered, and the trigger since the last assessment was “new”.

A review of resident #037’s health care record indicated that a RAP related to Behaviour Symptoms was not completed. In the assessment of an identified date, 10 RAPs for various care areas were triggered, and of the 10 triggered RAPs, only 1 Psychosocial Well-Being was written by a recreation staff member.

Resident #043:

In the RAI-MDS assessment of an identified date, resident #043 was coded as resisting care 4-6 days in the last 7 days, but less than daily. In the following assessment on an identified date the resident was coded as having resisted care on a daily basis. A Behaviour Symptoms RAP was triggered, and the trigger since the last assessment was "adjusted".

A review of resident #043's health care record indicated that a RAP related to Behaviour Symptoms was not completed. In the assessment of an identified date, 12 RAPs for various care issues were triggered, and of the 12 triggered RAPs, only 1 for Psychosocial Well-Being was written by a recreation staff member.

In the most recent RAI-MDS assessment, resident #043 was coded as being frequently incontinent of urine. In the assessment prior, the resident was coded as being incontinent of bladder. In the assessment of an identified date, a RAP related to Urinary Continence was triggered, and the trigger since the last assessment was "adjusted".

A review of resident #043's health care record indicated that a RAP related to Urinary Continence was not completed.

Resident #031:

In the past 3 RAI-MDS assessments (on identified dates), resident #031 has been coded as being frequently incontinent of bladder. In the last assessment date, a RAP related to Urinary Continence was triggered, and the trigger since the last assessment was "existing".

A review of resident #031's health care record indicated that a RAP related to Urinary Continence was not completed.

Resident #026:

In the past 4 RAI-MDS assessments (on identified dates), resident #026 has been coded as being frequently incontinent of bladder. In the last assessment date, a RAP related to Urinary Continence was triggered, and the trigger since the last assessment was "adjusted".

A review of resident #026's health care record indicated that a RAP related to Urinary Continence was not completed.

Resident #053:

In the most recent RAI-MDS assessment, resident #053 was coded as having a stage 1 and a stage 2 pressure ulcers. A RAP related to Pressure Ulcers was triggered, and the trigger since the last assessment was "adjusted"

A review of resident #053's health care record indicated that a RAP related to Pressure Ulcers was not completed.

Resident #050:

In the most recent RAI-MDS assessment, a RAP related to Behavioural Symptoms was triggered, and the trigger since the last assessment was existing.

A review of resident #050's health care record indicates that a RAP related to Behavioural Symptoms was not completed.

The inspector spoke with the RAI-MDS Coordinator and the RAI-MDS Coordinator back-up on January 17, 2016. The RAI Coordinator stated that he/she was aware of RAPs that were not completed as part of the RAI-MDS quarterly review. The RAI Coordinator indicated that since the end of August 2016, a RAI team had been implemented with a coder on each floor to code the MDS assessment and to update the care plans, and that the coders were now starting to complete the RAPs. [s. 101. (4)]

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 compliance with the conditions to which the licensee is subject to as it relates to RAI-MDS assessments for 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. The licensee has failed to ensure that resident #046's missing or unaccounted controlled substance was reported to the Director within one business day after the occurrence.

Related to Log #030199-16, Critical Incident Report (CIR)

During an interview on January 13, 2017 at approximately 1400 hours, the Director of Care (DOC) indicated to Inspector #601 that on an identified date and time the DOC discovered an email sent by RPN #100 three days prior. The email sent by RPN #100 indicated that resident #046's controlled substance that was applied to resident #046's body part on an identified date and time could not be located on the resident.

During the same interview, the DOC indicated to Inspector #601 that the identified medication is a controlled substance and the unaccounted identified medication should have been reported missing to the Director within one business day from the day it was identified as missing as per the legislation reporting requirements.

Resident #046's unaccounted for controlled substance was reported to the Director on an identified date, three business days after the incident was identified. [s. 107. (3)]

2. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Related to Log # 031637-16:

A critical Incident Report (CIR) was submitted to the Director on an identified date for an incident involving resident #041 who was transferred to hospital on an identified date due to an incident that caused an injury to a body part.

Review of progress notes for resident #041 indicated an entry, on the date of the incident that the resident was admitted to the hospital with an injury to a body part.

The Director was not notified of the incident until the CIR was submitted on an identified date two days after the resident's injury of the body part was confirmed. [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 all incidents related to missing or unaccounted substances and incidents that caused an injury to a resident that resulted in a significant change in the resident’s health condition and for which the resident was taken to a hospital are reported to the Director within one business day after the occurrence of each incident, to be implemented voluntarily.

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.