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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2019	2019_603194_0004	014836-17, 017710-17, 021527-17, 021608-17, 022160-17, 024403-17, 025955-17, 026685-17, 027974-17, 028077-17, 028095-17, 028806-17, 029477-17, 005867-18, 006734-18, 007488-18, 011402-18, 018109-18, 019493-18, 024544-18, 024829-18, 026614-18, 027088-18, 030069-18, 030070-18, 030071-18, 030072-18, 001204-19, 001659-19	Critical Incident System

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
CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 21, 22, 24, 25, 30, 31, February 4 and 5, 2019

The following logs were included during this inspection; Log #005867-18, Log #006734-18, Log #007488-18, Log #011402-18, Log #014836-17, Log #017710-17, Log #018109-18, Log #019493-18, Log #024403-17, Log #024544-18, Log #026614-18, Log #026685-17, Log #027088-18, Log #028077-17, Log #028806-17 related to falls; Log #030072-18 for follow up to order related to responsive behaviours, Log #030069-18 for follow up to order related to plan of care, Log #030070-18 for follow up to order related to duty to protect, Log #030071-18 for follow up to order related to immediate investigation into abuse, Log #022160, Log #024829-17,Log #028095-17 for unaccounted controlled substances, Log #021527-17, Log #021608-17 related to missing resident less than three hours, Log #025955-17, Log #027974-17, Log #029477-17, Log #001659-19, Log #001204-19 related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Resident Care Coordinators (RCC), Behavioural Ontario Support (BSO) RPN and PSW, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Pharmacist, Environmental Service Manager (ESM), Manager of Nursing Practice and Receptionist.

Reviewed clinical health records of identified residents, relevant policies, internal abuse investigation information. Observed staff to resident provision of care and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **6 WN(s)**
- **3 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 # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2018_578672_0009	166
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2018_578672_0009	166
O.Reg 79/10 s. 53. (4)	CO #003	2018_578672_0009	166
LTCHA, 2007 S.O. 2007, c.8 s. 6. (8)	CO #001	2018_578672_0009	194

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

During inspection of Critical Incident Report related to a fall involving resident #005 on an identified date, Inspector #194 reviewed the residents clinical health record, interviewed Registered staff and PSW.

Review of the progress notes for an identified period indicated that resident #005 had a number of falls.
- On an identified date resident #005 is found sitting on the floor in a common area, no injury was noted.
- The following month, resident #005 is reported to have three falls in common areas, with no injury.
- The following month, resident is found lying on their back on the floor in the co-resident doorway, with injury.
- The following month, resident has witnessed fall, in common area, with injury.

Interview with RPN #116 was conducted on an identified date related to resident #005 and falls interventions. RPN #116 described resident #005 as being restless. RPN #116 indicated that when resident #005 became tired the resident would exhibit specific behaviours and staff would implement identified interventions. RPN #116 indicated that interventions were only effective for a short period of time.

Interview with PSW #117 was completed by Inspector #194 on an identified date related to resident #005 and falls interventions. PSW #117 explained that resident #005 climbs, is fidgety and is unable to sit still. PSW #117 indicated that PSW staff would bring resident #005 close to them when charting to monitor for falls and indicated that the registered staff would monitor resident #005 in the lounge, when they were at the nursing station.

Review of the clinical health records was completed and resident #005 did not have a plan of care related to risk for falls until after the most recent fall.

The licensee failed to ensure that there was written plan of care that set out the planned care related to falls for resident #005. [s. 6. (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 by ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

As legislated under O. Reg 79/10, s.114(1) Every licensee of a long term care home shall have develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Review of the home's policy, Document No: MEDI-CL-ONT-042 , related to narcotic counts :

A count of all narcotics is to made on the Narcotic and Controlled Substance Administration Record. A check of the balance -on- hand must be completed by two nurses or care providers at the time of every shift change. The count and each

signatures are recorded in the appropriate column on the Narcotic and Controlled Substance Administration Record.

Related to log #0024829-18:

On an identified date a Critical Incident Report(CIR), was submitted to the Director reporting a controlled substance missing/unaccounted.

Review of the CIR documentation indicated that on an identified date, RPN #111 was to administer a controlled substance to resident #008. When RPN #111 pulled the medication card, it was noted that controlled substances were missing.

During review of the internal investigation by Inspector #166 was completed, on an identified date, documentation indicated that, RPN #111 called RPN #114 from the previous shift to enquire if the count was correct at the end of shift. Documentation further indicated that RPN #111 then called RN #113 to report the unaccounted controlled substance. The RPN and the RN searched for the controlled substance. The controlled substance was not located.

The resident's SDM and the police were notified of the incident. The incident did not impact the resident.

On an identified date, review of the licensee's investigation and interview with DOC indicated that during the licensee's investigation, it was discovered that Best Practice Guidelines and the licensee's policy, Document No: MEDI-CL-ONT-042 were not be consistently followed by the some of the registered staff.

On an identified date, interview with the Resident Care Coordinator #115, confirmed that during the licensee's investigation into the missing controlled substance, the registered staff were not following the licensee's policy MEDI-CL-ONT-042 , specifically the section which requires:
A check of the balance -on- hand must be completed by two nurses or care providers at the time of every shift change, when the controlled substance sheet (balance -on- hand) was not completed by two staff on an identified date, during shift change.

The licensee has failed to ensure compliance with their medication policy, related to the count of controlled substances when two registered staff did not complete a check of the balance-on-hand at the time of every shift change. [s. 8. (1) (a)]

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 by ensuring that the licensee's medication policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, a post fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Related to Log #027088-18:

During inspection of CIR related to a fall involving resident #005 on an identified date, Inspector #194 interviewed registered staff and Resident Care Coordinator.

During interview with Inspector #194, RPN #116, RN #118 and RCC#115 indicated that registered staff are to complete a post fall assessment/huddle for all residents post falls.

Review of the clinical health records for resident #005 for an identified period related to falls indicated resident #005 had falls on a number of specified dates. RCC #115 and Inspector #194 reviewed clinical health records for resident #005 related to post fall assessments. RCC #115 indicated that after review of resident #005's the clinical health

records, there was no documentation of post falls assessments completed, for the falls occurring on two specific dates, no injury to the resident as a result of these falls.

Related to Log #019493-18:

During inspection of CIR related to a fall involving resident #007 on an identified date, Inspector #194 interviewed Registered staff and Resident Care Coordinator.

During interview with Inspector #194, RPN #116, RN #118 and RCC#115 indicated that registered staff are to complete a post fall assessment/huddle for all residents post falls.

Review of the clinical health records for resident #007 for an identified period related to falls indicated resident #007 had falls two falls. RCC #115 and Inspector #194 reviewed clinical health records for resident #007 related to post fall assessments. RCC #115 indicated that after review of resident #007's the clinical health records, there was no documentation of post falls assessments completed, for one fall, with no injury to the resident.

Related to Log # 011402-18:

During inspection of CIR related to a fall involving resident #006 on an identified date, Inspector #194 interviewed Registered staff and Resident Care Coordinator.

During interview with Inspector #194, RPN #116, RN #118 and RCC#115 indicated that registered staff are to complete a post fall assessment/huddle for all residents post falls.

Review of the clinical health records for resident #006 for an identified period related to falls indicated resident #006 had four falls. RCC #115 and Inspector #194 reviewed clinical health records for resident #006 related to post fall assessments. RCC #115 indicated that after review of resident #006's the clinical health records, there was no documentation of post falls assessments completed, for one fall, with no injury to the resident.

The licensee failed to ensure that resident #005, #006 and #007 received post fall assessments using a clinically appropriate assessment instrument that is specifically designed for identified falls. [s. 49. (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 by ensuring that when a resident has fallen, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log #029477-17:

During inspection of the CIR for allegations of resident to resident abuse involving resident #016 and #017 on an identified date, it was noted that SDM's were not notified of the outcome of the abuse investigation.

The CIR described that the resident to resident abuse was unwitnessed. Resident #017 indicated being abusive towards resident #016. During the internal investigation it was indicated that resident #016 denied abuse of resident #017. Resident #017 had an injury as result of the abuse.

Review of the licensee's internal investigation and interview with DOC was completed by Inspector #194. The internal investigation did not provide any evidence that the SDM's

for resident #016 and #017 had been informed of the outcome of the homes internal investigation into the allegations of abuse. During interview with Inspector #194, the DOC confirmed that SDM's were not notified of the outcome of the abuse investigation

Related to Log # 025955-17:

During inspection of the CIR for allegations of resident to resident abuse involving resident #012 and #013 on an identified date is was identified that SDM's were not informed of the outcome of the abuse investigation.

CIR indicated resident #012 was being abusive towards resident #013, when staff entered the common area, residents were separated and resident #013 was assessed to have an injury and resident #012 was assessed to have an injury.

Inspector #194 reviewed the home's internal investigation, CIR, clinical health records for both residents and interviewed BSO/RPN and BSO/PSW related to the incident. There was no evidence to support that the SDM's for identified residents were notified of the results of the abuse investigation completed by the home. During interview with Inspector #194, the DOC confirmed that SDM's were not notified of the outcome of the abuse investigation

Related to Log #027974-17:

During inspection into CIR for witnessed incident of resident to resident abuse involving resident #014 and #015 on an identified date, indicated that SDM's were not notified of the results of the investigation upon the completion.

CIR indicated that on an identified date, HCA staff observed resident #014 being abusive towards resident #015, resulting in an injury.

Review of internal investigation and clinical health record by Inspector #194 did not provide any evidence that SDM's were notified of the outcome of the abuse investigation involving resident #014 and #015. During interview with Inspector #194, the DOC confirmed that SDM's were not notified of the outcome of the abuse investigation

The licensee failed to ensure that the resident's SDM's were notified of the results of the alleged abuse involving residents #012, #013, #014, #015 #016 and #017. [s. 97. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Log #029477-17:

During inspection of the CIR for allegations of resident to resident abuse involving resident #016 and #017 on an identified date, it was noted that the written report was submitted to the Director, 20 days after the reported incident of abuse.

Inspector #194 reviewed the homes internal investigation, clinical health records for identified residents, CIR and interviewed RPN/BSO and PSW/BSO. CIR indicated that on an identified date, resident #017 alleged being abused by resident #016. Internal investigation indicated that resident #016 denied any allegations abuse towards resident #017. Clinical health records and interviews confirmed injury to resident #017 as a result of the incident.

During interview with Inspector #194, DOC indicated that CIR for abuse incident that occurred on an identified date was not submitted to the Director until 20 days later. DOC indicated that the home was mistaken and felt the report was to be submitted within 10 business days.

The licensee failed to make a report to the incident of resident to resident an identified date. The CIR was submitted to the Director, 20 days after the incident of abuse was reported to the home. [s. 104. (2)]

WN #6: 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident’s health condition.
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 failed to ensure that the Director is informed when a resident is missing less than three hours, with no injury, no later than one business day after the occurrence of the incident.

Related to Log #021608-17:

During the inspection of CIR for an incident of resident #023 missing from the home less than three hours, with no injury, it was noted that Director was notified of the incident two days after it was reported.

Review of CIR indicated that resident #023, who was assessed by the home as being at risk for exit seeking behaviour, was observed on an identified date, walking up the side walk, outside the building by a staff member. The resident was noted to have been easily redirected back into the building and was not injured.

Inspector #194 reviewed the CIR which indicated that the MOHLTC after hours was not contacted.

During interview with Inspector #194, the DOC indicated that the Critical Incident Report involving resident #023 was not submitted within one business day as required.

The Licensee failed to ensure that the Director was informed within one business day, when resident #023 was missing less than three hours. The incident was reported to the Director two days after the incident. [s. 107. (3)]

Issued on this 25th day of February, 2019

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

Original report signed by the inspector.