Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 30, 2020	2020_838760_0044	017032-20, 017977-20, 024362-20	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

JACK SHI (760)

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): December 22, 23, 24, 2020 were conducted on site. December 29, 2020 was conducted off site.

The following intakes were completed in this critical incident inspection:

Two logs were related to falls;
One log was related to an allegation of resident abuse.

A complaints inspection #2020_838760_0043 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Care Coordinators (RCC), Occupational Therapist (OT), the acting Director of Care (A-DOC) and the administrator.

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004's plan of care was followed related to their fall prevention intervention.

A Critical Incident Systems (CIS) report was submitted by the home related to a fall that the resident sustained, resulting in a diagnosed condition. The resident's care plan had indicated they would use a fall prevention intervention. After their first fall, they had sustained a second fall and the progress notes had indicated that their fall prevention intervention was not present at the time of their second fall. An interview with the RPN indicated that when they responded to the incident, the staff member who had last provided care to the resident did not apply the fall prevention intervention to the resident and that the staff did not follow their care plan for the resident. There was potential risk of harm to the resident related to their fall prevention intervention, which could possibly prevent the resident from falling.

Sources: The resident's care plan, progress notes; Interview with an RPN and other staff. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that devices for the falls prevention and management program were readily available at the home.

A CIS report was submitted by the home related to the fall of resident #005. The resident's care plan indicated that they are always to use a fall prevention intervention. After their first fall, the resident sustained a second fall and a referral was made at that time to the OT for an alternate type of fall prevention intervention to be applied for the resident. The OT did not directly address the request at that time. The resident sustained a third fall and a referral was made again to the OT for an alternate type of fall prevention intervention to be applied for the resident, similar to the request made from the first referral after the resident's second fall. The OT provided the alternate fall prevention intervention after the second referral. An interview with an RPN who had responded to the resident's second fall, indicated that due to the resident's responsive behaviours, their original fall prevention intervention was ineffective. Another RPN, who responded to the resident's third fall, had indicated that the resident's original fall prevention intervention did not work, hence they made a referral to the OT for the alternate fall prevention intervention at that time. The OT clarified that the home did not have the alternate fall prevention intervention available for the resident to use after their second fall and it had arrived within the week of their third fall, which was why the resident had received it after the second referral to the OT. The OT had indicated that there may have been a benefit to the resident, had they received an alternative fall prevention intervention, after their second fall. There was potential risk of harm to the resident, as it was determined their original fall prevention intervention was not effective and required an alternative intervention, but none was available during a period at the home.

Sources: A resident's progress notes, care plan; interviews with the OT, two RPN's and other staff. [s. 49. (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 equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the investigation in an allegation of resident to resident abuse was reported to the Director.

A CIS report was submitted by the home related to an allegation of an abuse towards a resident. The CIS report did not indicate the results of the allegation of resident abuse. Interviews with two RCC's indicated that they could not recall updating the CIS report with the results of their investigation.

Sources: A CIS Report; Interviews with two RCC's and other staff. [s. 23. (2)]

Issued on this 4th day of January, 2021

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

Original report signed by the inspector.