Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2021	2021_784762_0013 (A1)	004056-21, 006696-21	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

Amended by MOSES NEELAM (762) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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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

This licensee inspection report has been revised to reflect the revocation of the Voluntary plan of correction (VPC) and Written notification (WN) in relation to S. 5. The Critical Incident System inspection, 2021_784762_0013 was completed on May 12, 2021.

The revision is for the following reason: The home had provided additional information and upon review, the VPC and WN were no longer applicable. As result, they are being rescinded.

A copy of the revised report is attached.

Issued on this 16th day of July, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by MOSES NEELAM (762) - (A1)

Amended 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): May 12-14, 17, 2021

The following intakes were completed in this Critical Incident System/Report (CIS/R) inspection:

Log related to an incident that lead to an injury for which the resident was taken to the hospital

Log related to infection control

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), Physiotherapist (PT), Senior Public Health Inspector (Sr. PHI), Resident Care Coordinator (RCC), Acting Infection Control Practitioner (AICP), Environmental Service Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses(RPNs), Environmental Service Staff (ES), Personal Support workers (PSWs) and Inspector #501 was present during the inspection

During the course of this inspection the inspector observed infection prevention and control practices, resident and staff interactions, and conducted observation on resident home areas.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control

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

3 WN(s)
1 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 #2: 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care that sets out the planned care for resident #001.

The resident was given a intervention on a certain date. This intervention was recommended by the physiotherapist and was implemented by the nurse on the same day. However, this intervention was not added to the written care plan until a few months later, which is printed out for the PSWs in the form of a Kardex as per the Long-Term Care Home's (LTCH) process. As a result, the resident was at risk for missing the intervention as this intervention was not present in the care plan and hereby the Kardex for a few months.

Sources: PCC care plan; PCC Progress notes; Interview with RCC #105 [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff who provided direct care to residents #001, #003 and #004, have convenient and immediate access to the contents of the plan of care.

The Long-Term Care Home (LTCH) currently uses a verbal report process and a PSW binder which contains the resident Kardex to communicate the written plan of care to the PSW's. A review of resident #001's Kardex in the PSW binder indicated that it was last updated in August, 2020. The residents current electronic plan of care had changed since August, 2020, hence, not matching with the Kardex in the PSW binder. As an example, certain care items in the Kardex was different than the current plan of care. In separate interviews, PSW #101 and RCC #105, indicated that the PSW's do not have access to the current plan of care in PCC. As a result, this put the resident at risk for not receiving the care in the updated plan of care, because the PSW's did not have convenient and immediate access to the plan of care.

Sources: Kardex last updated in August, 2020; PCC current care plan reviewed in May, 2021; Interviews with PSW #101 and RCC #105 [s. 6. (8)]

3. A review of resident #003's Kardex in the PSW binder indicated that it was last updated in May, 2021. The residents current electronic plan of care had changed since then, hence, not matching with the Kardex in the PSW binder. As an example, certain care items in the Kardex was different than the current plan of care. In an interview, RCC #105, indicated that the PSW's do not have access to the current plan of care in PCC. As a result, this put the resident at minimal risk for not receiving the care in the updated plan of care, because the PSW's did not have convenient and immediate access to the plan of care.

Sources: Kardex last updated in May, 2021; PCC current care plan; Interview with RCC #105 [s. 6. (8)]

4. A review of resident #004's Kardex in the PSW binder indicated that it was last updated in April, 2021. The residents current electronic plan of care had changed since April, 2021, hence, not matching with the Kardex in the PSW binder. As an example, certain care items in the Kardex was different than the current plan of care. In an interview, RCC #105, indicated that the PSW's do not have access to the current plan of care in PCC. As a result, this put the resident at minimal risk for not receiving the care in the updated plan of care, because the PSW's did not have convenient and immediate access to the plan of care.

Sources: Kardex last updated on May 5, 2021; PCC current care plan reviewed on May 14, 2021; Interview with RCC #105 [s. 6. (8)]

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 that there is a written plan of care that sets out the planned care, and staff who provide direct care to residents, have convenient and immediate access to the contents of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that any actions taken with respect to resident #001 under the falls program, including the assessment and intervention for discontinuing the an intervention is documented

The resident's care plan stated the resident required a certain intervention, this intervention was resolved in May, 2021. During a review of the electronic health record, there was no documentation of the assessment or rationale for the discontinuation of the intervention. However, in an interview, RPN #102, PT #103 and RN #104 indicated that the discontinuation was discussed verbally, but not documented. As a result, the staff of the LTCH would not know the rationale for the discontinuation of the intervention and hence there was a minimal risk on the continuity of care.

Sources: PCC current care plan; Interviews with RPN#102, PT #103, RN #104 and RCC #105 [s. 30. (2)]

(A1)
The following Non-Compliance has been Revoked / La non-conformité suivante a été révoquée: WN #2

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Issued on this 16th day of July, 2021 (A1)

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

Original report signed by the inspector.