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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Jan 14, 2022	2021_875501_0026	004397-21, 008021-21, 009003-21, 010156-21, 011448-21, 011905-21, 011906-21, 012058-21, 013009-21, 014888-21	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

SUSAN SEMEREDY (501), JULIE DUNN (706026), LYNDA BROWN (111)

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 14, 15, 16, 17, 20, 21, 22, 23, 2021.

The following intakes were completed in this critical incident (CI) inspection:
Log #014888-21 related to falls prevention
Log #013009-21 related to falls prevention
Log #012058-21 related to falls prevention
Log #011448-21 related to falls prevention
Log #010156-21 related to falls prevention
Log #008021-21 related to falls prevention
Log #004397-21 related to falls prevention
Log #011905-21 related to medication management
Log #011906-21 related to medication management
Log #009003-21 related to the prevention of abuse and responsive behaviours

NOTE: A Written Notification and Voluntary Plan of Correction (VPC) related to LTCHA s.19(1) and O.Reg 79/10 s. 8(1)(b) were identified in this inspection and have been issued in a concurrent inspection, #2021_875501_0025.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinators (RCCs), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist, Infection Control Practitioner, Manager of Food Services, Coordinator of Recreation and Therapy, Housekeeping Aides, Dietary Aides, Laundry Aides, Recreation Aides, Receptionist (COVID-19 testing), Surveillance Supervisor, family members, substitute decision-makers (SDMs) and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, medication administration and IPAC practices. The inspectors reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to live in a safe environment was fully respected and promoted.

A resident was known to have responsive behaviours. At one time their behaviours became extreme and the resident used physical force towards another resident. PSWs were able to intervene and the resident did not sustain any injuries. During an interview an RCC admitted the home was not a safe environment for residents during this incident.

Failing to provide a safe environment for residents put them at actual risk of harm.

Sources: Residents' clinical records including progress notes and interviews with an RCC and other staff members. [s. 3. (1) 5.]

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 every residents' right to live in a safe environment is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A resident was known to have responsive behaviours. Documentation indicated this resident became out of control and staff were unable to prevent the resident from entering other resident rooms. The staff tried to intervene but were unable to protect these residents. No physical injury or pain was identified.

Staff members were unable to take steps to manage the resident with responsive behaviours and an interview with an RCC stated staff could have taken additional steps to minimize the harmful interactions that occurred.

Failing to identify and implement interventions to minimize the risk of altercations puts residents at actual risk of harm.

Sources: A resident's progress notes and interviews with an RCC and other staff members. [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that is secure and locked.

A medication cart was found unattended and unlocked. An RPN was located at the nursing station and on the phone. The RPN later returned to the medication cart and was not aware they had left the medication cart unlocked. Later that same day, another medication cart was found unattended and unlocked. After several minutes, the RPN returned to the medication cart and indicated they had left to take a resident's vitals. They were unaware that they had left the medication cart unlocked. The DOC confirmed the expectation was that all registered staff are to lock their medications carts when not in attendance.

Sources: Observations and interviews with the DOC and other staff members. [s. 129. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to two residents in accordance with the directions for use specified by the prescriber.

An RPN discovered medications for two residents in the sharps container that had been signed on the electronic Medication Administration Record (eMAR), as administered by another RPN. The DOC confirmed an RPN had not administered the residents their medications and disciplinary action was taken as a result.

Sources: Critical Incident Report, eMARS and narcotic records for two residents, review of the home's investigation records and an interview with the DOC. [s. 131. (2)]

Issued on this 18th day of January, 2022

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

Original report signed by the inspector.