Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 27, 2024

Inspection Number: 2024-1559-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Regional Municipality of Durham

Long Term Care Home and City: Hillsdale Estates, Oshawa

Lead Inspector	**Inspector Digital Signature**
Rexel Cacayurin (741749)	Rexel J Cacayurin Digitally signed by Rexel J Cacayurin Date: 2024.05.31 16:11:06 -04'00'

Additional Inspector(s)
Eric Tang (529)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30, 2024 and May 1-3, 6-10, 13-14, 2024

The following intake(s) were inspected:

- Intakes: #00096489 -CI #M539-000070-23, #00098241 – CI #M539-000083-23 - related to an allegation of resident to resident abuse.
- Intake: #00099206 -CI #M539-000087-23 related to an allegation of staff to resident neglect.
- Intake: #00102736 – a complaint related to allegation of neglect to a resident.

- Intake: #00104675 - first follow-up to Compliance Order #001/Inspection #2023-1559-0003 - FLTCA, 2021 - s. 6 (4) (a) related to Plan of Care, Compliance Due Date (CDD) of April 18, 2024.
- Intake: #00104674 - first follow-up to Compliance Order #002/Inspection #2023-1559-0003 - FLTCA, 2021 - s. 24 (1) related to Duty to protect, CDD of April 18, 2024.
- Intakes: #00108962 - CI #M539-000024-24, #00109299 - CI #M539-000031-24 related to allegation of abuse to a resident.
- Intake: #00109334 - a complaint related to allegation staff to resident abuse.
- Intake: #00112353 -CI #M539-000037-24 related to outbreak.
- Intake: #00112616 – CI# M539-000038-24 related to fall.

The following intakes were completed in this inspection:

- Intake: #00091743 – CI #M539-000050-23, Intake: #00098321 – CI #M539-000082-23, Intake: #00106491 – CI #M539-000007-24, Intake #00109254 – CI #M539-000030-24, and Intake: #00107324 – CI #M539-000011-24 related to fall.

- Intake: #00098321 - CI #M539-000082-23 and Intake: #00104974- CI #M539-000112-23 related outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1559-0003 related to FLTCA, 2021, s. 6 (4) (a) inspected by Rexel Cacayurin (741749)

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Order #002 from Inspection #2023-1559-0003 related to FLTCA, 2021, s. 24 (1) inspected by Eric Tang (529)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee has failed to ensure the provision and outcomes of care for the resident were documented.

Rationale and Summary

A complaint and a Critical Incident Report (CIR) were submitted to the Director

alleging the resident was physically abused by staff with injuries found on the resident's body.

Record review indicated that the resident had experienced an incident one evening. The resident was immediately assessed by on-duty staff and no injuries were found at that time. As per the home's internal investigative notes, a staff had discovered an injury on the resident's body when providing care days later and had immediately reported to a registered nursing staff for their assessment.

Upon reviewing the resident's medical records, the registered nursing staff did not document their assessment and care provided to the resident for their injury.

The Director of Care (DOC) confirmed the same and further stated that the identified registered nursing staff was expected to chart the details of their assessment in an electronic progress note and escalate the concern if required.

There was a risk and impact to the resident as the lack of care documentation might have impacted the communication of the resident's health conditions amongst the healthcare team members.

Sources: CIR, complaint, home's internal investigative notes, the resident's electronic health records, and staff interviews. [529]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A complaint and CIR were submitted to the Director related to an alleged neglect incident of a resident by staff.

On a specified date, a complaint was sent to the home by a family member. They indicated that the resident was found in their specialized device sitting in their feces for quite a while during their visit.

The DOC confirmed that the home was made aware of the allegation of neglect on a specified date and the CIR was submitted to the Ministry of Long-term Care on a later date. Further, they have acknowledged that the home failed to immediately submit the report to the director.

Failure to immediately report allegations of neglect to the Director increased the risk of delayed follow-up actions.

Sources: CIR, the home's internal investigation documents, and an interview with DOC.[741749]

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
The Licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by resident at all times.

Rationale and Summary

A CIR was submitted to the Director related to a resident's fall.

The resident was observed sitting on a specialized device in their room attempting to grab the call bell, which was observed to be on the ground and tangled in bed. Registered Practical Nurse (RPN) confirmed that the resident was able to use the call bell when they needed assistance.

RN indicated that the resident was at high risk of falls. Further, they acknowledged that the home's expectation was to ensure that the call bell was within reach of the resident, untangled in bed and not on the ground.

Failure to ensure the call bell was easily accessible at all times, caused risk to resident's safety.

Sources: CIR, Observation, interviews with staff. [741749]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument designed for falls when the resident had fallen.

Rationale and Summary

A CIR was submitted to the Director alleging physical abuse between two residents. As a result of their interaction, one resident was being pushed away and fell on to the floor.

The resident's electronic health records were reviewed, but the identified post-fall assessment tool could not be found.

Resident Care Coordinator (RCC) and the DOC confirmed the same and that the post-fall assessment tool should have completed for the resident.

There was a risk and impact to the resident as the details of the falls might not have been fully communicated amongst the healthcare team members

Sources: CIR, home's internal investigative notes, the resident's electronic health records, and staff interviews. [529]

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when initial interventions were not effective.

Rationale and Summary

A CIR was submitted to the Director related to resident's fall with injury.
The resident had an unwitnessed fall and was found lying on the floor. They were sent to the hospital due to increased pain and returned to the long-term care home on the same day.

On a specified date, the resident complained of generalized body pain, their routine pain medication and an ice pack were given with some effect. Further, the resident continued to have pain throughout the shift.

The Pain Program lead and Manager of Nursing practice RN indicated that the home's expectation was to complete a comprehensive pain assessment when pain was not relieved by the initial intervention. They also confirmed that there was no comprehensive pain assessment completed on the specified date for the resident

Failing to complete a comprehensive pain assessment resulted in the resident's unmanaged pain.

Sources: CIR, interviews with staff. [741749]

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary

A CIR was submitted to the Director alleging a resident had physically abused another resident by pushing the resident.

As per the resident's electronic progress note, an intervention was initiated as a measure to assess and monitor the resident's condition after the incident. The identified intervention and its documentation were reviewed but there were multiple sections without assessment and monitoring information.

The BSO Program Lead and the Assistant Director of Care (ADOC) asserted that the intervention was to assess the resident's behavior and the information would assist with resident's care planning. Both staff confirmed that the identified intervention

and its documentation were not fully completed and that the document should have been fully completed by the nursing staff.

There was a risk and impact to the resident as the resident's behavior might not have recorded and therefore, impacting healthcare team members' understanding of the resident condition and effective care planning.

Sources: CIR, home's internal investigative notes, the residents' electronic health records, and staff interviews. [529]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, IPAC standard 9.1 (e) the licensee failed to ensure that additional precaution shall include Point-of-care signage indicating that enhanced Infection Prevention and Control (IPAC) measures were in place.

Rationale and Summary

A Personal Protective Equipment (PPE) caddy was observed outside a resident's room without additional precautions signage posted at the door. RPN confirmed that the resident was on isolation precautions due to respiratory symptoms and

indicated that the expectation was to have the additional precautions signage posted at the door. The IPAC lead confirmed the same.

Failing to ensure signage is posted outside the door of the resident who was under additional precautions increases the risk of the spread of infection in the home.

Sources: Observation, Interviews with staff, and review of the home's outbreak line lists. [741749]