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
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Public Report

Report Issue Date: December 23, 2024
Inspection Number: 2024-1559-0004
Inspection Type: Complaint Critical Incident
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18 - 20, and 23, 2024

The following intake(s) were inspected:

- Intake: #00131636 - M539-000105-24 - Complaint submitted by the LTCH regarding resident care.
- The following intakes were completed in this inspection: #00133130 - CI #M539-000110-24; #00133564 - CI # M539-000111-24; and #00133927 - CI #M539-000114-24 - Falls of residents resulting in injury.
- Intake: #00133689 - Complainant regarding resident care.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

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 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that interventions being utilized, and that are successful in assisting a resident regarding care, were listed in the written plan of care for staff to review and implement.

Sources:
Resident record review and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the substitute decision maker for a resident was updated and consent obtained regarding a new medication that was initiated.

Sources:
Resident record review, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that a resident had continuous 1:1 monitoring as set out in their plan of care.

Sources:
Review of resident health care record, observations, and interviews with staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to provide a required response to the complainant including the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010, an explanation of what the licensee has done to resolve the complaint, whether the licensee believes the complaint to be unfounded, together with the reasons for the belief, and confirmation that the complaint was forwarded to the Director.

Sources:
CIS #M539-000105-24 review and LTCH investigation folder and interview with staff.