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

Public Report

Report Issue Date: November 25, 2025
Inspection Number: 2025-1559-0008
Inspection Type:
Critical Incident
Follow up

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): November 17, 18, 19, 21, 24, 25, 2025

The following intake(s) were inspected:
- Two intakes related to Fall of resident resulting to injury.
- One intake related to Compliance Order follow-up #: 1 - FLTCA, 2021 - s. 6 (7) CDD November 19, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1559-0007 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Infection Prevention and Control
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 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

There was no documentation indicating that the registered staff had collaborated with the Physician to develop and implement a plan of care when resident #003 was not able to complete the diagnostic test on time. The result of the diagnostic test had also not been communicated to the physician in a timely manner.

Sources: Resident #003's clinical records and interview with the Resident Care Coordinator (RCC).

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Resident #003 returned to the home from the hospital with altered skin issue. The altered skin was supposed to be assessed weekly until it resolved; however, the skin assessment was not initiated on a timely manner.

Sources: Resident #003’s clinical record, Skin and Wound assessments, Interviews with Skin and wound lead and RCC.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain management program were complied with. Specifically, the home's pain policy stipulated that both pharmacological and non-pharmacological interventions are implemented.

Resident #003 sustained a fall that resulted in injury. A review of resident #003's clinical records, indicated that the resident expressed pain, after the fall incident occurred. Pain lead confirmed that interventions were not implemented for the resident.

Sources: Pain Management Policy, resident #003's clinical records, Critical Incident Report (CIR), interviews with Pain Lead.

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