Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 3, 2014 | 2014_195166_0021 | O-000739-14 | Complaint |

**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 TERRACES
600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

CAROLINE TOMPKINS (166)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): July 30, 31, 2014 and August 11,12, 2014**

**During the course of the inspection, the inspector(s) spoke with the Resident,Family members,Physician,Physiotherapist,Personal Support Workers (PSW),Registered Nurses(RN),Registered Practical Nurse(RPN),Resident Care Coordinator(RCC),Director of Care(DOC)and the Administrator.**

**During the course of the inspection, the inspector(s) observed the resident, observed the staff to resident interactions during the provision of care,reviewed clinical records,licensee/family meeting notes and the licensee's policy # HRD-02-02-15 Lifts and Transfer.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. Clinical documentation, interview with the Director of Care and interview with the Resident Care Coordinator, indicated that on an identified date, Resident#1 was taken to the bedside to be transferred to bed. The resident reached out to hold on to the bedside table while the staff member stood behind the resident to guide the resident to bed. The resident began to sit. The staff member guided the resident to the floor. There was no documented injury to the resident.
Resident #1's plan of care related to transfers at the time of the incident indicated:
- 2 staff transfer assist.
On the identified date of the incident, one staff was assisting the resident with the transfer.
The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

***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 the care set out in the plan of care related to transfers for Resident #1 is provided to the resident as specified in the plan., to be implemented voluntarily.***

**Issued on this 4th day of September, 2014**

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