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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2014	2014_365194_0017	O-000988-14	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 6,7,8,9,10,14,15,16 & 17, 2014

During the course of the inspection the following Complaint logs and Critical Incident Logs were completed. Log #O-000620-14,#O-000430-14,#O-000652-14,#O-000431-14,#O-000767-14,#O-000605-14,#O-000126-14,#O-000776-14,#O-001282-12,#O-000813-12

During the course of the inspection, the inspector(s) spoke with Administrator,Director of Care(DOC),Resident Care Coordinator(RCC), Registered Nurse(RN), Registered Practical Nurse(RPN),Personal Support Worker(PSW),Occupational Therapist(OT),Physio Therapy Aide Adjuvant (PTA),Environmental Services Manager(ESM),Environmental Services Housekeeper,RAI coordinator,Recreational Therapy Coordinator,Recreation/social activity aide,Infection Control Practitioner,Physician, Behavioural Support Ontario(BSO),Residents and Families

During the course of the inspection, the inspector(s) completed an initial tour of the building,observed resident's living areas, dining service, medication administration, infection control practices, resident/staff interaction and provision of care. Reviewed licensee's policy related to infection control, medication, prevention of abuse. Reviewed clinical health records for identified residents, reviewed meeting minutes Resident Council and Family Council. Reviewed internal investigation for identified Critical incidents

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physical restraining device is included in the plan of care.

During an observation of Resident #17 on an identified date it was noted that the resident was sitting in a wheelchair in a tilt position with a physical restraining device in place. Resident was asked to see if the physical restraining device could be unfastened. The resident was unable to unfasten the physical restraining device.

Review of the restraint monitoring form for resident #17 has been completed by PSW and RPN indicating hourly safety checks and application of the physical restraining device

Review of the written plan of care for Resident #17 indicated the physical restraining device was not included in the plan of care. [s. 31. (1)]

2. The licensee has failed to ensure that an order by the physician was obtained for the use of a physical restraint.

Resident #17 is a cognitively impaired resident, who is at high risk for falls and is unable to unfasten the physical restraining device when applied. PSW staff have confirmed that physical restraining device has been applied daily for Resident #17. Restraint Monitoring form has been completed by registered and non registered staff.

Resident #34 was observed sitting in a Broda chair with a physical restraining device. Resident #34 was asked by the inspector to unfasten the physical restraining device and the resident was unable to. PSW #202 was asked if Resident #34 could unfasten the physical restraining device and replied that the resident could not.

Review of the clinical health records for Resident #17 and #34 were completed. There is no evidence of physician's order for the application of the physical restraining device for either resident. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraint plan of care include the consent by the resident or SDM

Review of the clinical health records for Resident #17 and #34 were completed. There was no Substitute Decision Maker (SDM) consent for the use of a physical restraints. [s. 31. (2) 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 by ensuring that all physical restraints applied to residents are included in the plan of care, have a physician's order and an SDM or Resident consent., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Log O-000652-14
The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.
On an identified date, Staff #139 was assisting Resident #51 with a transfer resulting in an injury to the resident.
Review of Resident #51's plan of care and the physio assessments related to transferring indicated the resident required extensive -2 person assistance.
Interview with RN #134 indicated at the time of the incident, the resident's plan of care and transfer logo indicated Resident #51 required a 2 person transfer assist.
Interview with Staff #139 indicated at the time of the incident ,Staff #139 did not notice a transfer logo in the resident's room but was aware the Resident #51's transfer status required 2 person assist.
Interview with staff and review of clinical records indicated, Resident #51 was transferred with the assistance of one staff contrary to the resident's assessed transfer status. [s. 36.]

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 by ensuring that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to apply a physical restraining device in accordance with prevailing practices set out by OT, in place of manufactures instructions which were not available.

The RCC, OT and Adjuvant #122 were interviewed and have stated that the home does not have manufacturer's instructions for application of physical restraining device in the home. The Adjuvant #122 has stated that the prevailing practice at the home for application of physical restraining device is to allow a 2 finger width between the device and the resident.

Resident #44 was observed on an identified date sitting in the wheelchair with a physical restraining device. The physical restraining device had a gap of approximately 8 inches between the restraint and the resident. The plan of care for Resident #44 directs that the resident is at high risk for falls and sliding out of the chair.

Resident #14 on an identified date was observed sitting in a wheelchair with a physical restraining device with a gap of approx. 4 inches between the restraint and the resident. The PTA proceeded to tightened the physical restraining device. A clip was

in place on the physical restraining device that prevents the device from sliding or being pulled by resident to loosen. PTA needed to readjust the clip to tighten the device. PTA stated that from time to time these types of physical restraining device will loosen and need to be re tightened.

Resident #17 was observed on an identified date, sitting in a wheelchair in a tilt position with a physical restraining device in place. Resident was asked to see if the physical restraining device could unfasten. Resident #17 was unable to the unfasten the physical restraining device. The physical restraining device was applied loosely with 6 inch gap between the resident's abdomen and belt.

Interviews with Adjuvant #117 and RPN #118 were conducted related to the application of the physical restraining device for Resident #17. Adjuvant stated that the physical restraining device was "too loose" when the wheelchair was in a tilt position. Adjuvant #117 demonstrated for inspector that when the wheelchair was in the upright position the physical restraining device was applied properly, but when the wheelchair was placed in a tilt position the physical restraining device became too loose. The plan of care for Resident #17 directs the resident is at high risk for falls, cognitive impairment and poor judgement.

Resident #25 was observed on an identified date sitting in a Broda chair with a physical restraining device. Resident when asked was unable to unfasten the physical restraining device. The physical restraining device was applied with approximately an 8 inch gap between the resident's abdomen and the seat belt.

During an interview Adjuvant #122 stated that Resident #25 could not unfasten the physical restraining device. When the device was observed the Adjuvant stated that the physical restraining device was too loose and proceeded to tighten it. Adjuvant #122 stated to inspector that this resident's device was frequently loose. Adjuvant #122 indicated that the resident was having a bad day and that the resident often manuevers to the front of the chair seat. The plan of care for Resident #25 directs that the resident is at high risk for falls, unsteady gait, cognitive impairment,impaired vision, poor judgement and dementia.

Resident #25 was observed the following day, sitting in a Broda chair with a physical restraining device loosely applied. A gap of approx 6 inches noted between the device and the resident's abdomen. The resident is unable to unfasten the physical restraining device when asked. Adjuvent #122 was approached by the inspector about

the resident's restraint, she replied, I know. Adjuvent #122 stated the resident was up walking and had just been put back into the chair, because of being unsteady, the resident is usually walking around the physical restraining device is only "when needed". [s. 110. (1) 1.]

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 be ensuring that physical restraining devices are applied with prevailing practices set out by the OT., to be implemented voluntarily.

Issued on this 21st day of October, 2014

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