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 24, 2013	2013_195166_0038	O-000822-13	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): October 15, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with the Resident, the resident's Substitute Decision Maker(SDM), the Administrator, the Physician, the Resident Care Coordinators, the Registered Nurse, the RAI MDS Coordinator and the resident Adjuvant.

During the course of the inspection, the inspector(s) observed the resident, reviewed the resident's clinical health records, the licensee's responsive behaviour policy and the staff communication report.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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. 6. Plan of care

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Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care related to responsive behaviour set out clear direction to staff and others who provide direct care to the resident.
Clinical documentation and interview with registered staff indicated, Resident #1 on an identified date experienced a medical situation that temporarily changed the resident's behaviour and the resident's ability to function within their normal parameters.
The resident's written plan of care did not address these behaviours and did not give staff clear direction on how manage the resident's demonstrated behaviour. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident's substitute decision maker(SDM) was given the opportunity to participate fully in the development of Resident #1's plan of care.
Telephone interview with resident's SDM indicated that the SDM was aware the initial plan was to reduce the dosage of a specific medication . Clinical documentation, interview with the registered staff and interview with the SDM indicated the SDM was not informed each time the dosage was readjusted. [s. 6. (5)]

3. The licensee failed to ensure that the resident's plan of care was revised when the resident's care needs changed.
Clinical documentation, interview with the nursing staff and the resident's physician indicated that Resident #1, on an identified date experienced a medical situation that temporarily changed the resident's behaviour and the resident's ability to function within their normal parameter. The resident was administered anti psychotic medications.
There is no evidence that the resident's plan of care was revised when the resident's care needs changed related to a change in behaviour, the ability to perform activities of daily living within their normal parameter, and the administration of anti psychotic medications. [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident and that the resident is reassessed and the plan of care is reviewed and revised when the residents' care needs change., to be implemented voluntarily.

Issued on this 24th day of October, 2013

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