



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

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

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

**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  
Direction de l'amélioration de la  
performance et de la conformité**

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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 22, 2015	2015_365194_0010	O-001701, 001854, 001664	Critical Incident System

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### **Licensee/Titulaire de permis**

REGIONAL MUNICIPALITY OF DURHAM  
605 Rossland Road East WHITBY ON L1N 6A3

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### **Long-Term Care Home/Foyer de soins de longue durée**

HILLSDALE TERRACES  
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

CHANTAL LAFRENIERE (194), MARIA FRANCIS-ALLEN (552)

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

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 13,14,15,16 and 17, 2015**

**PLEASE NOTE: Non compliance under s.24(1) identified in this report will be issued under a Complaint Inspection #2015\_365194\_0009 Log#O-001539-15 concurrently inspected during this inspection**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Co ordinator (RCC),Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker(PSW), Resident, Environmental Service Supervisor (ESS), Social Worker (SW)and Housekeeping staff.**

**Also reviewed during the inspection; clinical health records, Licensee's internal investigation into abuse, staff educational records, licensee's policy on abuse. Observation of staff to resident provision of care.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. The licensee failed to ensure that care set out in the plan of care for Resident #3 related to toileting was provided as specified in the plan.

Resident #3 is capable of making independent treatment decisions. Resident #3 is wheelchair bound and is able to mobilize independently on the unit.

The plan of care for Resident #3 directs:

Continence Care plan;

To manage continence with regular toileting;

-scheduled toileting plan: every two hours routinely. Uses bedpan on the bed.

-uses bed pan frequently-will request when requires to use the bedpan

-uses incontinence brief- provide thorough peri care after each bowel movement- check every two hours and as needed, change incontinent product as required. Will request bed pan. Is incontinent of bowel and bladder.

On an identified date RPN #120 documented in Resident #3's progress notes that at identified time, the resident approached RPN #120 and asked to be toileted.

Documentation in the clinical health records indicate that Resident #3 had been toileted 3 hours earlier. RPN #120 stated to resident toileting would be completed if Resident #3 agreed to stay in bed, resident refused. An hour later the RPN #120 was approached by Social Worker and husband of Resident #3 related to the toileting request, toileting was still not provided. Resident #3 was toileted and assisted to bed, by RPN #120 and Health Care Aide (HAC) five hours after last toileting care was provided. [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 by ensuring that the plan of care set out for Resident #3 related to continence is provided as specified, to be implemented voluntarily.***



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**Issued on this 29th day of May, 2015**

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

**Original report signed by the inspector.**