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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2015	2015_270531_0011	O-006898-15	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

SUSAN DONNAN (531)

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): May 7 and 8, 2015

During the course of the inspection, the inspector(s) spoke with three Personal Support Workers, A Registered Practical Nurse, a Registered Nurse, the Occupational Therapist, the Physiotherapist, the Physician, the Coroner and the Director of Care.
During the Course of the inspection, the inspector reviewed the Critical Incident report, resident health care records including physician orders, manufactures instruction manual and the appropriate policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, c. 8, s. 6 (11)(b)whereby different approaches were not considered when care set out for a particular resident were not effective.

On a specified date a Critical Incident System report was submitted to the Ministry of Health and Long Term Care for an unexpected death of Resident #1.
Resident #1's diagnoses include multiple comorbidities.

The Critical Incident report describes the incident as follows:

On a specified date Resident #1 was observed at regular intervals by S#104 (PSW) and S#100 the Registered Practical Nurse, who observed the resident in bed. At an identified time S#100 found Resident #1 lying on his/her left side with his/her left cheek on the mattress and the right side of her chin against the side rail with the rest of the resident's body on the floor mat. The resident was wrapped in bedding. The resident's upper body was cool to the touch and his/her lower body was noted to be warm with vital signs absent. The motion sensor alarm was covered with a blanket.
S#100 and S#104 told inspector #531 that the blanket may have prevented or muffled the sound of the alarm as it was not audible at the time of the incident.
During interviews with S#101(the occupational therapist), S#103 (physiotherapist) and the Director of Care told inspector #531 that the incident was re-enacted and it confirmed that when covered with the blanket the motion sensor either did not alarm or the sound was muffled.
Review of Resident # 1's health care record indicated that the resident had been found in similar positions on the following occasions:
On a particular date S#110 noted the resident was found with her legs and knees on the floor. The Resident's alarm was attached and noted to be turned on, no sound present.
On an identified date S#111 noted that Resident #1's legs and hips were on the floor mat while the resident's upper body remained in bed. A small red area was noted on the left armpit where the resident's left arm had sat against the partial rail. S#111 made a referral to the occupational therapist (OT) noting that a wedge of some type may be useful in preventing the resident from rolling out of bed. There was no evidence to support that the OT assessment was completed. During an interview with S#101 he/she could not recall Resident #1 as having a wedge for the mattress.
On a specified date S#112 noted that the resident was found with both feet on the floor mat and the rest of his/her body pressed on the side rail. The resident had some redness

on his/her right side.
On a specified date S#113 noted that the resident was found sitting on the floor mat beside the bed.
On a particular date S#112 noted that the resident was found sitting on the floor mat beside the bed.
On a specified date the resident was found sitting on the floor mat leaning against the side rail and the bed alarm attached.
On a particular date PSW S#104, S#107 and S#108 told inspector #531 that when the motion sensor fails to alarm they replace the battery or the unit; they were not aware of a regular maintenance process for the sensors.
The Director of Care was interviewed related to documentation from the fall assessment, specifically the subtitle "found by staff or chime". The Director of Care confirmed that" found" meant that the chime alarm did not sound.
The resident's care plan dated on three separate intervals indicate that the Resident was at risk for falls/injuries. The physiotherapy progress note states that the resident is at high risk for falls and that the contributing factors included generalized weakness, fair balance, tendency to sleep with legs hanging over the bed, occasional dizziness, shortness of breath on exertion and falls history.
The resident's fall interventions included hourly checks or more frequently for safety , call bell within reach, two partial rails, floor mat, bed in the lowest position and a bed sensor alarm on the left side of the bed to alert staff when resident was getting up. The Resident required two staff to assist with transfers, bed mobility and toileting schedule. There were no changes to the other interventions despite Resident #1 having seven falls/near misses.

On a specified date during an interview with the Director of Care and a review of Resident #1's health record she confirmed that the home is in the process of revising the falls prevention program including interventions such as side rails, sensor alarms and maintenance function. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.23 by not ensuring that staff used the bed motion sensor alarm in accordance with the manufactures' instruction, which require the unit to be checked prior to each use.

On specified date a Critical Incident System report was submitted to the Ministry of Health and Long Term Care for the unexpected death of Resident #1.
Resident #1 had a history of falls and Resident #1's falls prevention plan of care included the use of a Alimed PIR alarm on the bed.

AliMed PIR Alarm manufactures instructions include the following:
PIR alarm relies on infrared technology to detect motion. The alarm is used to alert caregivers to patients or residents who have or are about to rise from bed. It is designed to be an early warning device.
Once an object has penetrated the detector field, unit will alarm for 30 seconds from initial detection of motion and then automatically reset.
If alarm /chime fail to sound and there are no obstructions in front of the lens, replace the battery immediately. If unit fails to work with new battery, replace unit.
Check unit before each use to ensure function.
S#100 and S#104 told this inspector that the blanket may have prevented or muffled the sound of the alarm as it was not audible at the time of the incident.
On a particular date PSW S#104, S#107 and S#108 told inspector #531 that when the motion sensor fails to alarm they replace the battery or the unit; they were not aware of a regular maintenance process for the sensors.
On a specified date during an interview with S#101 he/she confirmed he/she was not aware of a regular maintenance process to ensure the alarms are functional.

On a identified date S#101 was interviewed and confirmed that the incident was re-enacted and confirmed that when covered with the blanket the motion sensor either did not alarm or a soft muffled sound.

During interviews with S#101(the occupational therapist), S#103 (physiotherapist) and the Director of Care told this inspector that the incident was re-enacted and confirmed that when covered with the blanket the motion sensor either did not alarm or the sound was muffled. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufactures' instructions, to be implemented voluntarily.

Issued on this 17th day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_270531_0011
Log No. / Registre no:	O-006898-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 26, 2015
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	HILLSDALE TERRACES 600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	John Rankin

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when care set out in the plan has not been effective different approaches are considered in the revision of the plan to include the following.
1.Reassessment of all residents that are at high risk for falls to ensure the effectiveness of interventions to mitigate falls.
2.Different approaches are considered in the revision of the plan of care;
3.These assessments and approaches are to be documented to promote good communication between all team members.
4.Staff responsible for providing care and evaluating the effectiveness of the revised interventions are communicating the outcomes of their evaluation to the other members of the health care team so that the plan of care can be revised again;
5.The development of a monitoring process to ensure that all warning devices such as bed alarms are checked regularly to ensure the alarms are functional.

This plan must be submitted in writing to Inspector, Sue Donnan at 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4 or by fax at 1-613-569-9670 on or before July 10, 2015.

Grounds / Motifs :

1. The licensee failed to comply with the LTCHA 2007, c. 8, s. 6 (11)(b)whereby different approaches were not considered when care set out for a particular

resident were not effective.

On a specified date a Critical Incident System report was submitted to the Ministry of Health and Long Term Care for an unexpected death of Resident #1. Resident #1's diagnoses include multiple co-morbidities.

The Critical Incident report describes the incident as follows:

On a specified date Resident #1 was observed at regualr intervals by S#104 (PSW) and S#100 the Registered Practical Nurse, who observed the resident in bed. At an identified time S#100 found Resident #1 lying on his/her left side with his/her left cheek on the mattress and the right side of his/her chin against the side rail with the rest of the resident's body on the floor mat. The resident was wrapped in bedding. The resident's upper body was cool to the touch and his/her lower body was noted to be warm with vital signs absent. The motion sensor alarm was covered with a blanket.
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On a particular date S#113 noted that the resident was found sitting on the floor

mat beside the bed.
On a specified date S#112 noted that the resident was found sitting on the floor mat beside the bed.
On an identified date the resident was found sitting on the floor mat leaning against the side rail and the bed alarm still attached.
On a specified date PSW S#104, S#107 and S#108 told inspector #531 that when the motion sensor fails to alarm they replace the battery or the unit; they were not aware of a regular maintenance process for the sensors.
The Director of Care was interviewed related to documentation from the fall assessment, specifically the subtitle "found by staff or chime". The Director of Care confirmed that" found" meant that the chime alarm did not sound.
The resident's care plan dated on three separate intervals indicate that the Resident was at risk for falls/injuries. The physiotherapy progress note states that the resident is at high risk for falls and that the contributing factors included generalized weakness, fair balance, tendency to sleep with legs hanging over the bed, occasional dizziness, shortness of breath on exertion and falls history. The resident's fall interventions included hourly checks or more frequently for safety , call bell within reach, two partial rails, floor mat, bed in the lowest position and a bed sensor alarm on the left side of the bed to alert staff when resident was getting up. The Resident required two staff to assist with transfers, bed mobility and toileting schedule. There were no changes to the other interventions despite Resident #1 having seven falls/near misses.

On a specified date during an interview with the Director of Care and a review of Resident #1's health record she confirmed that the home is in the process of revising the falls prevention program including interventions such as side rails, sensor alarms and maintenance function.
(531)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

Service Area Office /
Bureau régional de services : Ottawa Service Area Office