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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 11, 2016	2016_195166_0020	013494-16	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

CAROLINE TOMPKINS (166), JULIET MANDERSON-GRAY (607), KARYN WOOD (601), SARAH GILLIS (623)

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): June 13-17, June 20, 21, 22 and June 24, 2016

Complaint logs 031963-15, 003543-16 , 008801-16, related to resident care, critical incident logs 006009-16, 0012504-16, 006123-16 related to allegations of resident abuse, critical incident logs 017941-16, 011045-16 related to falls and 011546-16 related to missing resident were inspected concurrently with this inspection

During the course of the inspection, the inspector(s) spoke with Residents , Family Members, representatives of the Resident and the Family Councils, Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Resident Care Coordinators(RCC), Director of Care(DOC), Registered Dietitian (RD), Physiotherapis(PT), Recreation staff, Social Worker(SW), Food Service Supervisor(FSS), Occupational Therapist(OT), Administration -Reception, Environmental Service Manager(ESM), Maintenance, Housekeeping staff, Dietary Aide, RAI Coordinator, Personal Support Worker- student and Recreation Manager.
During the inspection the inspectors observed staff to resident interactions , toured resident home areas, resident rooms and common areas, observed a meal and snack service, medication administration, infection control practices and resident activity programs.
The inspectors reviewed clinical health records, the licensee's investigation documentation and the licensee's policies related to: Prevention, Reporting and Investigation of Abuse and Neglect, Falls Prevention and Management Program, Skin and Wound Care Program and Restraint Minimization

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **3 VPC(s)**
- **0 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. (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 is provided to residents as specified in the plan.

Related to log #017941-16:

Review of a Critical Incident Report(CIR)identified that resident #051 had a fall and sustained an injury.

Review of resident #051's plan of care at the time of the fall identified that resident #051 did not have a history of falls however was a high risk for potential falls and injury.
Review of clinical documentation indicated the Occupational Therapist documented that a high low bed, bed alarm and fall mat were in place for resident #051.
Interview with PSW #113, RN #122, RN #124 and RCC #137 indicated the floor mats were in the resident's room but were not in place at the time of the resident's fall. [s. 6. (7)]

2. Related to log # 011546-16

A Critical Incident (CIR) was received reporting a missing resident < 3hours.
Clinical documentation indicates that on identified date and time, a staff member, who had just finished work observed resident #032 by a shopping area not far from the home. The staff member returned the resident to the home . The resident had no adverse effects and the resident's Substitute Decision Maker)SDM was notified of the incident.

Review of clinical documentation for resident #032 indicated that after this reported incident, resident #032 left the home two more times without authorization.

Review resident #032's plan of care and interventions, indicated the following;
Resident #032 is ambulatory, has a history of going out on unauthorized absence, goes out the front doors of the building and is not able to get back in to the building
Interventions:
Resident #032 has a monitoring device and is able to use the elevator.
Monitor whereabouts for safety and SDM to be advised when resident leaves premises.

During an interview RPN#153 confirmed that resident #032 has a monitoring device in place and will exit the building and leave the property.
During an interview RPN#147 indicated on the evening shift if resident #032 exits the building and the alarm is activated, the EC(Emergency Coordinator) RN will call resident #032's home area and alert the staff that the resident has exited the building so that they know to monitor.

During an interview RN#152 and RN#149 confirmed that resident #032 has a monitoring device and is capable of entering the door code and bypassing the alarm. RN#149 indicated that resident's SDM is aware of the risks and that resident #032 knows the bypass code for the elevator and the front door and will go outside unattended. The SDM would like the monitoring device to remain in place so that staff are alerted to when resident #032 leaves the building.
RN confirms that the resident is observed by staff hourly .

If the resident exits the front door on the day shift, the reception will notify the unit that the resident is outside, the RN would then notify the family(SDM) that resident #032 had exited the building.

RN#149 indicated that the home's expectation is that the RN(EC)(Emergency Coordinator) receives the alert from the monitoring system and that the designated RN (EC) is expected to alert the nurse in resident #032's home area, that resident #032 is outside.

During an interview RN(EC)#154 indicated she is the Emergency Coordinator (EC) for the home and the first responder to the wander guard alarm. RN#154 stated that she answers the alarm when she can get to it, but if she is busy with a resident, she might not be able to respond as quickly to the alarm .
RN#154 confirmed that when she does respond to the alarm, she will take a look to see if she can visualize the resident that activated it, and shut the alarm off. If it is resident #032 who has gone through the door, she does not notify resident #032's home area. RN #154 stated that resident #032 goes outside all the time and she believes that this is allowed.

RCC#143 confirmed resident #032 was found off the premises and returned to the facility two more times after the first reported incident and that resident #032's SDM was not notified that resident #032 had exited the building and was off of the property.
[s. 6. (7)] (601) [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 care set out in the plan of care:
1. related to the use of fall mats at the bedside for resident #051
2. related to notifying resident #032's SDM and notifying the nurse in resident #032's home area when resident #032 leaves the building
is provided to these residents as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that financial abuse of resident #044 had occurred , immediately report the suspicion and the information upon which it was based to the Director.

Related to log #006123-16

On an identified date a Critical Incident Report (CIR)was received reporting alleged financial abuse of resident #044.
Review of CIR, the licensee's investigation, interview with the Social Worker(SW#125) and the Administrator, indicated the Social Worker was advised that a family member of resident #044 and resident #044 wanted to bring forward a concern of alleged financial abuse of resident #044 .

The Social Worker #125 indicated , that immediately following the interview with resident #044 and the family member, the Administrator and Resident Care Coordinator(RCC) #124 were notified via email of the alleged financial abuse.

Approximately eight days after becoming aware of the allegation of financial abuse, the Administrator directed RCC #137, to submit a critical incident to the Director reporting the alleged incident of financial abuse and to notify the police. [s. 24. (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 to ensure that a person who has reasonable grounds to suspect that financial abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of:
1. A resident who is missing for less than three hours and who returns to the home with no injury of adverse change in condition.

Related to Log#011546-16
During the course of the inspection for a CIR related to a missing resident less than three hours that occurred on identified date the following was noted;
Resident #032 has a history of exiting the home and leaving the property.

Review of clinical documentation for resident #032 indicated that resident #032 left the home two more times without authorization.

On both occasions a CIR was not completed and the Director was not notified of the missing resident less than three hours. RCC#143 confirms that it is the homes expectation that the RN documents incidents of this nature in residents' clinical records as "Incident – AWOL" and an alert would be immediately emailed to the RCC and DOC to indicate follow-up required. [s. 107. (3)] (623)

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 the Director is informed no later than one business day after the occurrence of the incident of a resident who is missing for less than three hours and who returns to the home with no injury of adverse change in condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Related to log #006123-16

A Critical Incident(CIR) was received , reporting an alleged incident of financial abuse of resident #044.
Review of CIR , the licensee's investigation, interview with the Social Worker(SW#125) and the Administrator indicated that the Social Worker was advised that a family member of resident #044 and resident #044 wanted to bring forward a concern of financial abuse of resident #044.
The Social Worker #125 indicated , that immediately following the interview with resident #044 and the family member, the Administrator and Resident Care Coordinator(RCC) #124 were notified via email of the alleged financial abuse

Approximately eight days after the initial allegation was brought forward, the Administrator directed RCC #137, to notify the police.[s. 98.]

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.