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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Oct 3, 2016	2016_291194_0024	027308-16, 027716-16, 027741-16	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 19, 20 and 21, 2016

The inspection included Critical Logs #027308-16 related to missing resident and #027716-16 and #027741-16 related to allegations of resident/resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Social Worker and Physician

The inspector reviewed identified resident care health records, internal abuse investigation report and relevant policies.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

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 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 sets out clear direction to staff and others who provide direct care to the resident, related to the monitoring of the wandering behaviour .

Resident #001 is capable of ambulating independently without aides in/out of the home. Resident #001's communication has been affected and the resident's speech is limited. Resident #001 has a mild cognitive impairment. All staff interviewed have indicated that resident #001 is capable of ambulating outside the home independently. Resident #001 is non compliant with signing out of the home and a wander guard was trialled. The wander guard was unsuccessful. Recently a new device has been trialled for the resident's wandering behaviour.

Resident #001 has a history of elopement at the home. During a one month period there have been 3 incidents of elopement for resident #001. No injury related to elopements have been reported. Review of resident #001's written plan of care related to wandering has been reviewed and directs;

unsafe wandering/wander guard
GOAL: Prevent unauthorized absence-encourage resident to remain on premises to maintain safety
INTERVENTIONS:
-Apply wander guard to resident's wrist
-resident wears a wander guard. Resident is able to use the elevator and punch front door code. Resident is encouraged to remain on property however continues to wander off the premises.
-hold afternoon alcohol order PRN as per resident's POA if resident leaves home premises unauthorized.
-monitor whereabouts for safety
-Contact SDM to advise of resident leaving the premises

Plan of care post new device;

unsafe wandering/new device
GOAL: prevent unauthorized absence-encourage resident to remain on premises to maintain safety
INTERVENTIONS:

Apply new device to resident's left wrist
-resident wears new device on left wrist. Resident is able to use the elevator and punch front door code. Resident is encouraged to remain on the property however continues to wander off the premises and outside of the homes grounds
-monitor whereabouts for safety

During interviews RN #106, #109, #110, RPN #107, SW #111and RCC #100 were asked how the resident #001's whereabouts were monitored. All staff interviewed indicated that informal checks of resident #001 were being completed through out the day.

The written plan of care for resident #001 related to wandering does not identify, who will complete the monitoring, how often the monitoring will occur, where the monitoring is documented. The plan of care has not indicated the resident's pattern for leaving and duration of the leaves. There are no time lines or directions for staff to follow if the resident does not return. [s. 6. (1) (c)]

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 written plan of care for resident #001 sets out clear direction to staff and other who provide direct care related to monitoring of the wandering behaviour, to be implemented voluntarily.

Issued on this 3rd day of October, 2016

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

Original report signed by the inspector.