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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 26, 2018	2017_594624_0030	027764-17	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

BAIYE OROCK (624)

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): December 6 and 7, 2017

Log #027764-17, related to a complaint of a resident fall with injury, was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), and a family member.

A tour of the resident home area was completed and observations made of staff to resident interaction during the provision of care, resident's room, and the resident. A review was completed of resident's progress notes, falls risk assessments, pain assessments, physiotherapy assessments, Medication Administration Records (MAR), written plans of care as well as the policy and procedure related to falls prevention and management.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

The Licensee failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate

access to it related to resident #001.

Resident #001 sustained a fall on an identified date, was sent to hospital and returned two days later with a specified diagnosis on a specified body part and an order for the resident not to perform a prescribed task to the specified body part that was noted to be injured.

According to a family member, while visiting the home on a specified date, five days after the fall, the family member noticed a Personal Support Worker (PSW) assisting resident #001 in a mobility aide with the resident’s injured body part in a state that was concerning to the family member. The family member indicated that the PSW assisting the resident, the Registered Practical Nurse (RPN) and the Registered Nurse (RN) on the unit at the time of the observation were all not aware that resident #001 had sustained an injury to the said body part and had an order to not perform a specified task to the body part.

Nine days after the fall, PSW #102 and RPN #103, present and on duty in the home area of resident #001 at the time of the incident, were interviewed by Inspector #624 and both indicated that the licensee’s expectation is that when there has been a change in a resident status or condition, that the change is communicated through shift change report as well as included in the resident`s plan of care. Both PSW #102 and RPN #103 indicated that they were not made aware of the injury sustained by resident #001 at the start of their shift on the date of the complaint. They both indicated that they became aware of the injury when the resident’s family member inquired from them if they knew resident had an injury. Both staff members, indicated during the interview that at no point during the day of the complaint was the resident made to perform the task the resident was not supposed to perform.

Based on reviews of the resident's health records, interviews with staff and the complainant, there was no indication the resident suffered any additional injury on the day of the complaint and there was no indication that resident #001 had been made to perform the task the resident was ordered not to perform after the fall.

In an interview with the Director of Care (DOC) nine days after the fall, the DOC also indicated that the licensee’s expectation is that any change in residents’ condition is communicated to staff via shift change reports and then the residents’ care plan is reviewed and revised to reflect the changes. The DOC indicated that when the family member approached her and complained about staff not being aware of resident #001’s injury, the DOC spoke to the staff working at the time and they were not aware of the

change in the resident status but should have been informed during the shift change report. The DOC also indicated that the RN who was in the home and on duty when the resident returned from the hospital, should have updated the written plan of care, which was not done until three days later.

The licensee failed to ensure that staff who provided direct care to resident #001 were kept aware of the contents of resident #001's plan of care and had convenient and immediate access to it. [s. 6. (8)]

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 whenever a resident is sent to hospital and returns with a change in condition, staff and others who provide direct care to the resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

Issued on this 26th day of January, 2018

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

Original report signed by the inspector.