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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 28, 2018	2018_623626_0001	025931-17	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

DENISE BROWN (626)

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): January 22, 23, 24, 25 and 26, 2018. On February 23, 2018, an off-site interview was conducted.

The following intake log was inspected during the course of the inspection:

Intake Log #025931-17: Related resident care

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Environmental Service Manager, Physician, MDS-RAI Coordinator, Registered Nurses (RN), and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Programmer, residents and a family member.

During the inspection, the inspector observed resident to resident interactions, staff to resident interactions and the provision of care. The inspector also reviewed residents' health records, internal related complaints and investigations records as well as applicable policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, related to medication administration.

Related to Log #025931-17, pertaining to resident #001:

During an interview on a specified date, resident #001's family member indicated that no notification was provided to the family, as requested when the resident refused medications.

A review of the resident's plan of care on a specified date, did not indicate that the family member's request was documented in the plan of care.

In an interview on a specified date with Registered Practical Nurse (RPN) #100, the RPN indicated that the resident would sometimes refuse medications and was re-approached

when this occurred. In the same interview the RPN indicated, that staff would contact the family member and that the family member also frequently contacted the home. The RPN also indicated that the information to notify the family, when the resident refused medications was not noted in the resident's health records.

During another interview on a specified date, Registered Nurse (RN) #107 indicated that the resident was re-approached when medications were refused. If the resident continued to refuse the medications, the family member was notified.

In an interview on another specified date, the Director of Care (DOC) indicated, that resident #001's family member had requested to be notified when the resident refused to take the medications. It was not the expectation of the home that staff notify a resident's family member, each time that the resident refused medications. The DOC also indicated, that the family member's request should have been documented in the plan of care.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others, who provide direct care to the resident. Resident #001's family member requested to be notified when the resident refused medications and this information was not found in the plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care as set out in the plan of care was documented, related to falls.

Related to Log #025931-17, pertaining to resident #001:

A review of the resident #001's plan of care related to falls prevention, which was updated on a specified date, indicated that the resident had an alarm device in place to alert staff if the resident attempted to get out of bed unattended.

Another review of the Nursing Flow Sheet on a specified date, indicated that the Personal Support Workers (PSW), did not sign to indicate that the alarm device was checked, to ensure that the device was in place and functioning. There was no signage found on the flow sheets for a number of dates.

During the inspection the resident was observed by Inspector #626 on three separate dates, the resident was found in a mobility device with the alarm device in place and

During an interview on a specified date, RPN #100 indicated being aware that the alarm device was not in place on occasions when the resident was in the mobility device. The RPN also indicated not being aware of having measures in place to ensure that the alarm device was applied.

In another interview PSW #106 indicated, being aware that the device was not in place on a few occasions. The PSW also indicated that the alarm device was noted on the flow sheet.

In an interview on a specified date, PSW #108 indicated forgetting to apply the alarm device and this was discovered by the resident's family member. The PSW also indicated that the alarm device was noted on the flow sheet.

In an interview, the DOC indicated that it is the expectation that the PSWs sign-off the related section on the flow sheet to document that the alarm was checked. In another interview on a specified date, the DOC indicated that the direction to check the alarm device to ensure that it was in place and functioning, would not be written in the plan of care. The device was noted on the Nursing Flow Sheet, with the expectation that it was checked.

The licensee has failed to ensure that the provision of care as set out in the plan of care was documented. Staff did not consistently document on the Nursing Flow Sheet on each shift, that the alarm device was checked to ensure that it was in place and functioning. [s. 6. (9)]

3. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care, related to falls.

Related to Log #025931-17, pertaining to resident #001:

During a seven month period, the resident sustained a number of falls. One of these falls resulted in injury.

A review of resident #001's written plan of care over the specified period in which the

resident experienced multiple falls, contained a number of falls interventions. A further review of the resident's written plan of care, indicated that it was updated on two separate specified dates but it was not revised to include new interventions, although the resident had a number of falls within this period. In the same review, the written plan of care was noted to be updated on two later separate dates to include new fall prevention interventions.

In an interview on a specified date, PSW #106 indicated that the resident was at risk for falls and would climb out of bed. In another interview on another specified date, PSW #108 also indicated that the resident was at risk for falls and would get out of bed without assistance.

During an interview RPN #100 indicated, that the resident was at risk for falls as the resident would get out of bed without assistance. In the same interview RPN #100 also indicated, that the written plan of care was not revised to include new interventions until a specified date, after the resident had sustained a number of falls.

In an interview, the DOC indicated that it is the expectation that the plan of care is reviewed and revised, if the current falls interventions were not effective.

The licensee failed to ensure that when the resident was reassessed, the plan of care was revised because care set out in the plan was not effective. Resident #001 experienced a number of falls in a seven month period, including sustaining an injury and different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others, who provide direct care to the resident and to document the provision of care. The licensee shall ensure that when a resident is reassessed and the plan of care is reviewed and revised, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 1st day of March, 2018

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

Original report signed by the inspector.