Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2019	2019_715672_0014	011322-19, 012825-19, 016551-19, 017310-19	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

JENNIFER BATTEN (672), SAMI JAROUR (570)

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): September 3-6, 9-13, 16-20, 2019

The following intakes were inspected during this complaint inspection:

Log #011322-19, regarding a complaint related to a possible trespasser on the property and the emergency protocol practices in the home

Log #017310-19, regarding a complaint related to infection control practices in the home

Logs #016551-19 and #012825-19, regarding two complaints related to withholding approval for admission to the home

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinators, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Social Worker (SW), Environmental Services Manager (ESM), Environmental Services Workers (ESW), Physicians (MD), Staffing Clerks, Nursing Admin Assistants, Infection Control Nurse (ICN), residents, family members, and visitors to the home.

During the course of this inspection, the Inspectors, toured specific resident rooms and common resident areas, observed resident to resident and staff to resident interactions, reviewed clinical records, relevant policies to this inspection and the licensee's internal investigations documentation.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Infection Prevention and Control
Safe and Secure Home

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

- **2 WN(s)**
- **2 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	Légende 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Long-Term Care Homes Act, 2007 s.87.(1) states:

Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, (a) measures for dealing with emergencies;

In accordance with Ontario Regulation 79/10 s. 230.(4) states:

The licensee shall ensure that the emergency plans provide specific direction for identified emergency situations.

Related to Log #011322-19

The Ministry of Long-Term Care (MLTC) received a complaint, regarding an unknown intruder who entered the home on a specified date and indicated to staff an identified threat that could cause potential harm.

A phone interview was carried out with the complainant who indicated that a person walked into a resident home area and claimed to have an identified threat that could

cause potential harm and communicated this information to staff. The person was walked out of the home but remained on the property. The complainant indicated that once the person walked out of the building they spoke to staff who were standing outside of the home and told the staff they had another identified threat that could cause potential harm. Although the person was removed from Hillsdale Terraces, they could have walked across the parking lot to the other long-term care home on the property, Hillsdale Estates. The complainant indicated that they were concerned that procedures were not followed, and an emergency code procedure was not initiated.

On a specified date, the Environmental Manager (EM) provided Inspector #570 with a document titled "Incident at Hillsdale Terraces". A review of the document indicated that on a specified ate and time, a person entered in through the front door and walked into a resident dining room where they sat a table with backpack between their legs. When staff approached this person and asked if they were visiting, they indicated having an identified threat that could cause potential harm. Staff members immediately left and contacted management to let them know of the situation. The Administrator and Environmental Manager arrived in the dining room and escorted the person out of Hillsdale Terraces and off of the property. At this time the Administrator contacted the police. There were no emergency codes called. The document further stated that actions would be taken to educate staff on how and when to call emergency codes, along with holding mock codes.

A review of the Joint Occupational Health and Safety Committee Meeting Minutes regarding the incident indicated that bomb information was not mentioned until the person (intruder) left the building. The Administrator and Environmental Manager only knew that there was a problem and the codes should have been called.

An interview was carried out with PSW #146 who indicated that on the specified date, a person walked into the resident dining room and sat in the far back corner with a back pack between their legs. When asked if they were there to visit somebody, their response was threatening. The PSW indicated they reported the incident to RCC #103. The RCC phoned the Administrator or The Environmental Manager and both came to the dining room and both talked to the person in the dining room. The PSW indicated that they were familiar with emergency codes and that no code was called related to this incident.

An interview was carried out with Staff #137 who indicated that on the specified date and time, an unknown person walked into the resident dining room and sat with their knapsack in between their legs. When PSW #146 asked if they were visiting, they

indicated having an identified threat that could cause potential harm. PSW #146 went to notify the RCC and within minutes the Administrator and Environmental Manager had a discussion with the person and told them they were going to escort them off the premises. The person left without any incident. Staff #137 indicated that no emergency codes were activated that day.

An interview was carried out with Resident Care Coordinator (RCC) #103 who indicated that PSW #146 immediately reported the incident and was saying there was somebody in the dining room. The RCC indicated, as they did not know what to expect, they called the Administrator and the Environmental Manager who came right away. The RCC indicated that PSW #146 indicated observing a suspicious person. The RCC indicated that no codes were called as the situation was under control and the person was not violent. The RCC further indicated that they did not activate the specified emergency code as they did not know what was going on at that point and that the Administrator intervened right away and dealt with the intruder.

An interview was carried out with the EM who indicated that on the specified date, the Administrator stated there was a situation, somebody from outside (public) was in the resident dining room and staff were concerned with that individual being in the dining room. The Administrator spoke to this person and this person was walked outside the building across the parking lot and was off the property to the neighbouring road. The EM indicated that when they came back to the dining room with the Administrator, staff reported that this person indicated a potential threat. The EM indicated that had they knew all the details, they would have acted differently by calling 911 right away and would still have gone down to move people away from the area. The EM further indicated the police was called after the incident and that staff should have initiated the emergency code, but no code was called specific to this incident.

An interview was carried out with the Administrator who indicated that they received a phone call that there was an issue in an identified resident dining room. The Administrator and Environmental Manager responded and there was a person there and they said that they were there because their mother or father worked there; the person left without any issues when they were escorted outside the building and off the property. The Administrator indicated that they were not aware of the specified threat that could cause potential harm until afterwards when they spoke with the staff. The Administrator further indicated that the police was called after the person was escorted out of the building. The Administrator further indicated that this person was escorted outside to ensure residents were safe, and that no codes were called. Ultimately the staff should

have called the specified emergency codes.

The licensee failed to ensure that the home's emergency code policy was complied with when the police were not immediately called and when the specified emergency code was not called. [s. 8. (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 all emergency plans in place in the home are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to Log #016551-19:

A complaint was received by the Director, submitted by a case manager at the Central East Local Health Integration Network (CELHIN) indicating applicant #001 had been refused admission to Hillsdale Terraces LTC Home, located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission from the licensee, indicated the applicant was refused admission to the long term care home because the home lacked the nursing expertise to meet the applicant's care requirements.

The explanation provided by the licensee in the refusal letter was that the applicant had exhibited responsive behaviours. These responsive behaviours had apparently increased, according to a Behavioural Assessment Tool provided by the CELHIN when compared to a previous assessment provided to the licensee, when the applicant had been approved for admission to the LTCH. The licensee further indicated in the letter that the exhibited responsive behaviours would require applicant #001 to reside on the specialized unit due to safety reasons. The letter stated the licensee was concerned about further responsive behaviours exhibited by the applicant, based on the information presented to them in the CELHIN application for placement, specifically related to a concern that the "responsive behaviours that persist on that unit would only trigger the applicant's responsive behaviours". The letter was signed by the Social Worker.

Applicant #001 currently resided in another long-term care home and was placed on the crisis list for transfer to Hillsdale Terraces, due to the need to move to a secured unit.

During record review, Inspector #672 reviewed the "Placement Services Behavioural Assessment Tool", which indicated the applicant had exhibited identified responsive behaviours less than one time per week, which were brief incidents of less than one minute in duration and occurred in predictable situations. Redirection was effective in stopping the behaviours from escalating. The assessment tool further stated that the applicant exhibited a specified behaviour a specified number of times per week in a predictable situation. Lastly, the assessment tool stated that the applicant exhibited an identified responsive behaviour which occurred once in the last 12 months. Redirection was effective in stopping the behaviour from reoccurring.

During an interview, the Social Worker indicated they forwarded a copy of the applicant's Placement Services Assessment Tool provided by the CELHIN to the DOC, after making the final decision to deny applicant #001's admission to the LTCH. The Social Worker stated the DOC agreed with the decision to deny applicant #001's admission to the home. The Social Worker further indicated they believed the applicant was not

appropriate for admission to the LTCH due to not having enough staff present on the unit to monitor applicant #001, which would be required due to the responsive behaviours exhibited by the applicant and to ensure the safety of the other residents on the unit. The Social Worker further indicated that the home had a secured specialized care unit, which applicant #001 would have been residing on. The nursing staff had received education and training related to responsive behaviours and there was a Behavioural Supports Ontario (BSO) team functioning in the home.

During an interview, the DOC of Hillsdale Terraces indicated they"supported the decisions made by the Social Worker to deny applications to the home", and if the SW felt an applicant was not appropriate, they would sign off on denying the application. the DOC further indicated that the home had a secured specialized care unit, the nursing staff had received education and training related to responsive behaviours and the licensee had a BSO team in the home, which assisted the staff in managing residents with exhibited responsive behaviours.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements. [s. 44. (7)]

2. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to Log #012825-19:

A complaint was received by the Director, submitted by a case manager at the Central East Local Health Integration Network (CELHIN) indicating applicant #002 had been refused admission to Hillsdale Terraces LTC Home, located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the nursing expertise to meet

the applicant's care requirements.

The explanation provided by the licensee in the refusal letter was that the applicant had exhibited responsive behaviours. These responsive behaviours had apparently increased, according to a Behavioural Assessment Tool provided by the CELHIN, when compared to a previously provided assessment to the licensee, when the applicant had been approved for admission to the LTCH. The licensee further indicated in the letter that "There are major concerns that our home would not be equipped to safely manage your care. As such, admitting you would be a predictable safety risk to you, the current residents and the staff within our home. Thus, we are unable to accept your application at this time" related to applicant #002's exhibited responsive behaviours. The letter stated the licensee was concerned about further responsive behaviours exhibited by the applicant, based on the information presented to them in the CELHIN application for placement. The letter was signed by the Social Worker.

Applicant #002 currently resided in an identified health care centre. Applicant #002 was placed on the crisis list for transfer to Hillsdale Terraces due to the need to transfer the applicant out of the identified health care centre, after the applicant had been stabilized, as applicant #002 was not a permanent resident of the centre.

During record review, Inspector #672 reviewed the "Placement Services Behavioural Assessment Tool", which indicated the applicant had exhibited a specified responsive behaviours in the past, but these behaviours had not been present while the applicant resided in the last two identified health care centres, therefore required no interventions. The assessment tool also indicated applicant #002 had a history of another identified behaviour in the past year, but the behaviour had not been present for a specified time period, therefore no interventions were required.

During an interview, the Social Worker indicated they forwarded a copy of the applicant's Placement Services Assessment Tool provided by the CELHIN to the DOC, who made the final decisions regarding admission to the LTCH. The Social Worker indicated the DOC had indicated the applicant was not appropriate for admission to the LTCH due to the nursing staff not having the expertise to deal with the responsive behaviours exhibited by applicant #002. The Social Worker further indicated that the home had a secured specialized care unit, and the nursing staff had received education and training related to responsive behaviours.

During an interview, the DOC of Hillsdale Terraces indicated that the home had a secured

specialized care unit, and the nursing staff had received education and training related to responsive behaviours. The DOC further indicated the licensee had a Behavioural Supports Ontario (BSO) team in the home, which assisted the staff in managing residents with exhibited responsive behaviours.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements. [s. 44. (7)]

3. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out the contact information for the Director.

Related to Log #012825-19:

This inspection was initiated related to a complaint received by the Ministry of Long Term Care, submitted by a case manager at the Central East Local Health Integration Network (CELHIN), related to applicant #002. The complaint pertained to withholding approval for admission to Hillsdale Terraces LTC Home.

An application for admission was made to the LTC home. A letter from the Social Worker on behalf of Hillsdale Terraces LTC Home, addressed to the applicant, denied the application for admission to the home and included all of the required information under the legislation except for the contact information for the Director.

During separate interviews, the Social Worker and DOC confirmed the reasons the application for admission was denied. The Social Worker and DOC further indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice which set out the contact information for the Director. Following review of the refusal letter, the Social Worker and DOC indicated the letter did not meet the requirements, as it did not provide the contact information for the Director to the applicant. [s. 44. (9)]

4. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out the contact information for the Director.

Related to Log #016551-19:

This inspection was initiated related to a complaint received by the Ministry of Long Term Care, submitted by a case manager at the Central East Local Health Integration Network (CELHIN), related to applicant #001. The complaint pertained to withholding approval for admission to Hillsdale Terraces LTC Home.

An application for admission was made to the LTC home. A letter from the Social Worker on behalf of Hillsdale Terraces LTC Home, addressed to the applicant, denied the application for admission to the home and included all of the required information under the legislation except for the contact information for the Director.

During separate interviews, the Social Worker and DOC confirmed the reasons the application for admission was denied. The Social Worker and DOC further indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice which set out the contact information for the Director. Following review of the refusal letter, the Social Worker and DOC indicated the letter did not meet the requirements, as it did not provide the contact information for the Director to the applicant. [s. 44. (9)]

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 all letters withholding admission to the home includes all required information listed in the regulations and admission is only withheld when there is evidence to support how the home lacks the nursing expertise to meet the applicant's care requirements, to be implemented voluntarily.

Issued on this 27th day of November, 2019

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

Original report signed by the inspector.