Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Nov 17, 2020	2020_598570_0011	024360-19, 002102-20, 003140-20, 004272-20, 004880-20, 010217-20, 012348-20	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

SAMI JAROUR (570)

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): October 7, 8, 9, 13, 14, 15, 19, 20, 21, 22 and 23, 2020.

The following intakes were completed in this inspection:
Seven logs related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinators (RCC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also toured residents' home areas, observed resident to resident interactions and staff to residents interactions, reviewed residents' health care records, reviewed investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #005, #006, #007, #008, and #009 were protected from abuse by resident #004.

For the purposes of the Act and Regulation:
Physical abuse is defined as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident

The Ministry of Long-Term Care (MLTC) received five critical incident system (CIS) reports related to allegations of resident to resident abuse by resident #004 toward residents #005, #006, #007, #008 and #009.

Progress notes for residents #004, #005, #006, #007, #008 and #009 and CIS reports submitted to the MLTC for incidents related to resident #004 indicated that residents #005, #006, #007, #008 and #009 sustained injuries caused by resident #004 over a five month period.

Resident #004’s clinical records identified that the resident had responsive behaviours and that interventions put in place may only be effective for a short period.

The plan of care for resident #004 identified the resident's responsive behaviours with identified triggers. Interventions to respond to the resident’s behaviours were identified in the plan of care. The plan of care did not include a specified intervention that was described as an effective intervention by staff.

Interviews conducted with PSWs #120 #122, #123, RN #106, and #121 indicated the specified effective intervention to manage resident #004's responsive behaviours was not consistently provided to the resident.

The home did not have a consistent intervention for resident #004's responsive behaviour putting residents at risk of harm.

Sources: Critical Incident System (CIS) reports, clinical records for residents #004, #005, #006, #007, #008 and #009, interviews with PSWs #120 #122, #123, RN #106, #121, and RCC #115. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #004 and residents #005. #006, #007, #008 and #009 by identifying and implementing interventions.

The Ministry of Long-Term Care (MLTC) received five critical incident system (CIS) reports related to allegations of resident to resident abuse by resident #004 toward residents #005, #006, #007, #008 and #009.

Progress notes for residents #004, #005, #006, #007, #008 and #009 and CIS reports submitted to the MLTC for incidents related to resident #004 indicated that residents #005, #006, #007, #008 and #009 sustained injuries caused by resident #004 over a five month period.

The plan of care for resident #004 identified the resident's responsive behaviours with identified triggers. Interventions to respond to the resident’s behaviours were identified in the plan of care. The plan of care did not include a specified intervention that was described as an effective intervention by staff.

The progress notes for resident #004 were reviewed and indicated the a specified intervention was implemented following two incidents involving residents #008 and #009.

Interviews conducted with PSWs #120 #122, #123, RN #106, and #121 indicated a specified intervention which was effective was not consistently implemented to manage resident #004's responsive behaviours.

The home did not have a consistent intervention for resident #004's responsive behaviour putting residents at risk of harm.

Sources: Critical Incident System (CIS) reports, clinical records for residents #004, #005, #006, #007, #008 and #009, interviews with PSWs #120 #122, #123, RN #106, #121, and RCC #115. [s. 54. (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 to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying and implementing interventions, to be implemented voluntarily.

WN #3: 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 abuse of resident #005 by resident #004, that resulted in harm or risk of harm to resident #005, was immediately reported to the Director.

Resident #005 sustained an injury that was caused by resident #004. The incident of alleged abuse involving resident #005 by resident #004 was not reported to the Director until four days after the incident had occurred.

Sources: CIS report, clinical records for residents #005 and #004, interviews with RN #106 and RCC #115. [s. 24. (1)]

Issued on this 18th day of November, 2020

[redacted]

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

Original report signed by the inspector.