Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
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Original Public Report

Report Issue Date: 2023-09-25	
Inspection Number: 2023-1625-0002	
Inspection Type: Critical Incident	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Hillsdale Terraces, Oshawa	
Lead Inspector Najat Mahmoud (741773)	**Inspector Digital Signature**
Additional Inspector(s) AngieM King (644)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 23 to 25, 28 to 31, 2023 and September 1, 2023

The following intake(s) were inspected:

- An intake related to falls prevention and management.
- An intake related to alleged resident neglect
- Two intakes related to responsive behaviours.
- An intake related to missing/unaccounted for controlled substances.

The following intake(s) were completed in this inspection:

- Four intakes related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Behaviours and altercations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among the residents.

Rationale and Summary:
A Critical Incident Report (CIR) was submitted to the Director following an incident where a resident physically assaulted another resident. Clinical records indicated that both residents had cognitive impairment and responsive behaviors and that both residents were left unsupervised at the time of the incident.

The written plan of care was reviewed and did not identify triggers for the aggressor's responsive behaviors. The plan of care identified specific interventions for each resident to help mitigate responsive behaviours.

During interviews with the staff, the staff indicated that the victim was known to be a trigger for responsive behaviors for the aggressor. The staff also acknowledged that the written plan of care did not contain this information. Furthermore, the staff acknowledged that the two residents should not have been left unsupervised and that there had been continued incidences of altercations between them.

Failure to ensure that procedures and interventions were developed and implemented for resident's known behavioral triggers placed the residents at risk for injury and did not minimize the risk of altercations between the two residents.

Sources: CIR, Clinical records for resident, interviews with staff.

[741773]

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to implement written policies and protocols in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; related to 1) documentation of administered drugs and 2) narcotic count at shift change.

Rationale and summary
1) The licensee's written policy indicated they were required to ensure that narcotics, controlled and controlled like drugs were signed for each time a monitored medication was administered. Documentation included date, time, signature of nurse amount given, amount wasted and quantity remaining.

A CIR related to missing/unaccounted for controlled substances was submitted to the Director. A review of the Narcotic and Controlled Drug Administration Record Binder with Registered staff revealed missing documentation on date, time, signature, amount given and quantity remaining for six residents' medications.

The staff acknowledged that there should have been documentation immediately after the medications were administered and that the expectations in the home were to document within the hour of administering narcotics or controlled substances.

Failure to document the date, time, signature, amount given and quantity remaining posed a risk to the residents as the residents were at risk for medication overdosing.

Sources: CIR, Narcotic and Controlled Drug Administration Record Binder, the home's policy, interviews with staff.

2) The licensee is required to ensure that the written policy on narcotics, controlled and controlled like drugs were complied with as it relates to procedures on counting narcotics at shift exchange.

A CIR related to missing/unaccounted for controlled substances was submitted to the Director. A review of the Narcotic and Controlled Drug Administration Record Binder with Registered staff revealed missing incoming signatures.

The licensee's policy states, 'incoming and outgoing nurses are required to count and verify the remaining monitored medications and document accordingly. Both nurses are responsible to ensure the date, time and quantity of medication and their signatures are recorded during the count'.

The staff confirmed that the expectation is for both outgoing and incoming nurse to count the medications and sign at shift exchange when the narcotic count is performed. The staff also acknowledged that this was not done which compromised the accuracy of the count and increased the risk for potential medication incidences.

Failure to ensure that there were incoming nurse signatures in the Narcotic and Controlled Drug Administration Record Binder posed a risk to the safety and well being of the residents.

Sources: CI, Narcotic and Controlled Drug Administration Record Binder, the home's policy, interviews with staff. [741773]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee failed to ensure that the medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
A CIR was submitted to the Director related to missing/unaccounted for controlled substances.
The medication incident report was reviewed, and it was unclear if the resident had received a second dose of medications.

Review of the clinical records for the resident identified there were no assessments completed for the resident following the discovery of the medication incident.

The staff indicated since it was unclear if the resident had received an additional dose of medications, that an assessment should have been completed along with immediate actions taken to determine if the resident experienced any ill effects of the medications. The staff also confirmed that it is an expectation to document their assessments in the progress notes section of Point Click Care (PCC) and confirmed that there were no documented assessments for the resident.

Failure to document the resident's assessment following a medication incident posed a risk to their health and well-being.

Sources: CIR, Medication Incident Report, the home's policy, clinical records, and interviews with staff.
[741773]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The licensee failed to ensure that a medication incident which involved a resident was reported to the resident's attending physician.

Rationale and Summary:
A CIR was submitted to the Director related to missing/unaccounted for controlled substances.
The medication incident report was reviewed, and it was unclear if the resident had received an additional dose of medications. The medication report and the clinical records for the resident did not contain information on whether the resident's physician had been informed of the possible additional dose.

The staff indicated that since it was unclear if the resident had received additional doses of medications, that the physician should have been informed as per the home's process.

Failure to inform the physician regarding the medication incident posed a risk to the resident's health and well-being.

Sources: CIR, Medication Incident Report, the home's policy, clinical records, and interviews with staff.
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