Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 26, 2024	
Original Report Issue Date: June 7, 2024	
Inspection Number: 2024-1625-0002 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Hillsdale Terraces, Oshawa	
Amended By Reethamol Sebastian (741747)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:

CO #001 updated as Education will be in person and delivered by the Administrator or Social Worker for the licensee.

CO #002; Rationale and Summary paragraph six has been updated with information provided by the long-term care home. Paragraph nine removed the content; they do not read progress notes.

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Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Hillsdale Terraces, Oshawa	
Lead Inspector Reethamol Sebastian (741747)	**Additional Inspector(s)** Holly Wilson (741755)
Amended By Reethamol Sebastian (741747)	**Inspector who Amended Digital Signature**

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CO #001 updated as Education will be in person and delivered by the Administrator or Social Worker for the licensee.
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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15 - 17, 21 - 24, 27 - 29, 2024.

The following intake(s) were inspected:

An intake related to Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b)
An intake related to Follow-up #: 1 - O. Reg. 246/22 - s. 138 (1) (a) (ii)
An intake related to Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 9
An intake related to a complainant regarding alleged staff-to-resident abuse
An intake related to a complainant regarding resident-to-resident responsive behaviors
An intake related to a complaint on behalf of a resident - multiple concerns identified
An intake related to alleged resident-to-resident physical abuse
An intake related to alleged staff-to-resident neglect.
An intake related to alleged staff-to-resident physical abuse.
An intake related to the enteric outbreak declared

Five intakes related to falls were bundled in this inspection.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1625-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Reethamol Sebastian (741747)

Order #003 from Inspection #2024-1625-0001 related to O. Reg. 246/22, s. 138 (1) (a) (ii) inspected by Holly Wilson (741755)

Order #001 from Inspection #2024-1625-0001 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Reethamol Sebastian (741747)

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect a resident from abuse by a PSW.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director with an allegation of abuse of a resident by a Personal Support Worker (PSW).

The Registered Practical Nurse (RPN) was administering medications in the hallway and heard loud voices coming from inside a resident's room. The RPN entered the room to find a PSW holding down a resident while another PSW gave care. The RPN noticed the resident in distress and immediately called the Registered Nurse (RN) who gave first aid.

A record review indicated that the resident may experience responsive behaviors to and during personal care. The care plan recommended multiple interventions for staff for the resident's responsive behaviors. The PSW had recent training on all the interventions in the care plan.

An interview with the Resident Care Coordinator (RCC), RN, RPN, and Director of Care (DOC) confirmed that the identified interventions in the care plan were not utilized, resulting in abuse of the resident.

Failure of a PSW to utilize techniques identified in the care plan resulted in a resident suffering abuse.

Sources: CI Report, a resident's care plan and assessments, interviews with staff. [741755]

WRITTEN NOTIFICATION: Reporting certain matters to the Director.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

Rationale and Summary

1. A Critical Incident (CI) was submitted to the Director regarding an allegation of abuse of resident to resident. During the inspection, there were several incidents of documented verbal, physical, and sexual abuse, which were not immediately reported to the Director.

A record review indicated multiple documented incident reports of physical, physical aggression between co-residents over a specific period.

Interviews with Behavioral Support Ontario (BSO) RPN, RN, RCC, DOC, and Nurse Practitioner (NP) confirmed they are trained and know where to locate the Abuse Policy. However, they did not report the instances of documented incidents immediately to the Director, as they did not consider these instances to be reportable.

The documented instances were not reported to the Director and further incidents could occur without proper follow-up and investigation.

Sources: CI Report, progress notes and care plan of a resident, interviews with staff.

[741755]

2. The licensee has failed to immediately report the allegation of abuse of a resident by PSW.

Rationale and Summary:

A CI was submitted to the Director regarding an allegation of abuse on a particular day when the CI took place the day before.

A RPN was administering medications in the hallway and heard loud voices coming from inside a resident's room. The RPN entered the room to find a PSW holding down a resident while a PSW gave care. The RPN noticed the breakdown in skin integrity on the body of a resident and immediately called an RN. The RN gave first aid, completed a skin assessment, and identified an alteration in skin integrity. The RN called the on-call manager/RCC about the incident.

An interview with the RCC confirmed that the RN did not explain the entire incident and did not question how a resident sustained an alteration in skin integrity. An interview with the RN and RPN confirmed they did not report the allegation of abuse to the Director as the RCC did not advise them to do so. An interview with RCC and DOC confirmed that all staff in the home have been trained on how to identify and report an allegation of abuse to the Director.

The allegations of staff-to-resident abuse were not reported to the Director and further incidents could occur without proper follow-up.

Sources: CI Report, Abuse and Neglect – Prevention, Reporting, and Investigation Policy ADM-01-03-05, last reviewed December 28, 2023, Interviews with staff.

[741755]

WRITTEN NOTIFICATION: Policies and Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee failed to ensure their Falls Prevention and Management Program, was complied with, specifically related to reducing the incidence of falls and the risk of injury of a resident.

Rationale and Summary

A CI was submitted to the Director and indicated that a resident had four falls in a month while residing at the Long Term Care Home (LTCH). All the falls were unwitnessed. The resident sustained an injury on the fourth fall and was hospitalized.

The licensee's policy, Falls Prevention and Management Policy directs when a resident has a fall the registered nursing staff are to collaborate with the interdisciplinary team and send appropriate referrals to physiotherapy (PT)/Occupational Therapy (OT)/Environmental Services (ES) as needed.

As per the clinical record, the resident had an unwitnessed fall in the common area and an unsteady walking pattern contributed to the fall. The registered staff failed to send a referral to PT/ OT and the resident had further falls resulting in a significant change in condition and hospitalization. Interviews with PT and OT indicated that the

additional fall prevention intervention was initiated on readmission of the resident from the hospital. The DOC confirmed that registered staff failed to send a referral to PT/OT for the resident related to their falls due to unsteady walking as per the licensee's policy.

Failure to send the referral to PT/ OT related to the resident's post-fall may have contributed to the resident's further falls and injury due to a fall and hospitalization.

Sources: Resident's Clinical records, interviews with staff, and Fall Prevention and Management Policy #: INTERD-03-08-01, revised October 2021
[741747]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions, and the resident's responses to interventions are documented.

The licensee has failed to ensure actions were taken to respond to the needs of the resident who was demonstrating responsive behaviours, including reassessments and interventions.

Rationale and Summary

A complaint was lodged to the Director regarding the resident's wandering behaviour into other residents' rooms.

The resident's clinical records indicated they increased walking and wandering to other residents with the current interventions in place. During an observation, the inspector noted, that the resident continued to wander to other residents' rooms. The responsive behaviour interventions were ineffective and not revised.

Interviews with PSW, RPN, and RN indicated they did not know how many residents needed the intervention, and no one assessed the effectiveness of the current intervention. The LTCH policy for Responsive Behaviour indicates plans of care and resident-specific strategies to prevent and manage responsive behaviours will be communicated to all staff providing care on a shift-by-shift basis as well as on an ongoing basis.

The clinical health record for the resident failed to demonstrate that interventions were reassessed when strategies had not been effective, specifically wandering to other residents' rooms.

Failure of the licensee to reassess the resident and implement new interventions when strategies to manage the resident's responsive behaviours were ineffective, placed other residents at risk of harm.

Sources: Resident Clinical records, Observation, Interviews with staff, and Responsive Behaviour Prevention and Management Program Policy #: INTERD-03-09-01, Revise November 2022.

[741747]

WRITTEN NOTIFICATION: Hazardous substances

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous

substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that hazardous substances at the home were kept inaccessible to residents.

Rationale and Summary

During the initial tour at the LTCH, it was observed that the housekeeping cart with cleaning chemicals was kept in spray bottles hanging in the holder of the cart and easily accessible to residents. The cart did not have a lock to store the hazardous cleaning materials.

An interview with the Environmental Service Worker (ESW) indicated that the cleaning substances are always kept in the LTCH cart's holder and did not have a lock to store the hazardous chemicals. The Environment Service Supervisor (ESS) acknowledged that the housekeeping cart contained hazardous substances and should not be accessible to residents. The LTCH home's policy indicated that housekeeping carts were equipped with a locked compartment for storage of hazardous substances and each cart was always locked when not attended.

Failing to ensure that hazardous substances were always kept inaccessible to residents, could potentially cause harm to a resident, if not handled correctly or if ingested, inhaled, or absorbed.

Sources: Observations, interviews with staff, and Storage of Hazardous Substances and Chemicals Policy #: OPER-06-01-11 Revised Date: December 2022. [741747]

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was investigated and resolved and a response is provided within 10 business days of the receipt of the complaint.

Rationale and Summary

A Complaint was lodged to the Director related to alleged verbal abuse by RPN to a resident. The complainant informed the concerned staff in the LTCH.

The RPN indicated that the RCC was investigated regarding the incident with RPN in the presence of a union representative. RCC confirmed that the alleged abuse was not founded however failed to acknowledge and respond to the complainant.

The DOC confirmed that RCC did not acknowledge and respond to the complainant.

Failure to acknowledge and respond to the complainant regarding a complaint resulted in an unresolved complaint.

Sources: Resident's clinical records, Interviews with staff, and Management of Complaints Policy # #: ADM-01-07-19, Revised June 2022
[741747]

WRITTEN NOTIFICATION: Retention of records

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 282 1.
Retention of records
s. 282. Every licensee of a long-term care home shall retain the records required under section 281 in accordance with the following:

If a staff member ceases to work at the home, the record shall be retained for at least seven years after the staff member ceased to work at the home, and, for at least the first year, the record shall be retained at the home.

The licensee has failed to keep terminated employee records in the home for at least the first year for a PSW.

Rationale and Summary

A CI was submitted to the Director with an allegation of abuse of a resident by a PSW. The home terminated the employment of the PSW. As part of the inspection of the CI, the inspector requested the employment records of the PSW.

An interview with the Administrator confirmed that the records for all employees are kept at the corporate office of the licensee. The Administrator had to make a formal request to the corporate office of the licensee and records were made available later in the day.

Failure to keep terminated employment records in the home for at least a year slowed the inspection process.

Sources: PSW employment records, interview with Administrator
[741755]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate all staff, including the Doctor, NP, RCC, and DOC in the resident home area on the types of residents to resident abuse, specifically physical, verbal, and sexual abuse. This will also include how and when to report an allegation of abuse by any staff member to the Director. . Education will be in person and delivered by the Administrator or Social Worker for the licensee.

2. Keep a copy of all attendees of education, dates of the education the name of the educator/consultant, and the content of the education and make it available to the inspector upon request.

Grounds

The licensee has failed to protect a resident from abuse by another resident.

Rationale and Summary

A CI was submitted to the Director regarding an allegation of abuse of a resident by another resident, where they sustained an alteration in skin integrity.

A resident was known to exhibit behaviors of physical aggression towards co-residents.

The care plan for the resident indicated specific interventions to manage their responsive behaviours. The Behavior Support Ontario (BSO) team was following the resident.

A record review indicated that multiple physical aggressive incidents were documented of this resident towards co-residents. The Dr wrote a progress note that the resident had several incidents and that the timing of a medication would be changed. During a specific period, there were daily progress notes by registered staff noting interventions were ineffective.

Interventions to manage a resident's tendencies to apply physical aggression to co-residents were not effective and another resident received physical abuse.

Sources: CI Report, progress notes and care plan of a resident, incident reports. [741755]

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #002 Behaviours and altercations

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are 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 residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate Behavior Supports Ontario team members, including the NP, RCC for the resident home area, and DOC on PIECES (physical, intellectual, emotional,

capabilities, environment, social) assessment which is required in the Responsive Behavior Policy for residents displaying responsive behaviors. This education will be done by a consultant specializing in the PIECES assessment framework.

2. PIECES assessment will be completed on a specific resident, and this will be communicated to all staff on resident home area.
3. Keep a record of the dates of training, the attendees, and the name of the educator. This will be made available to the inspector upon request.

Grounds

The licensee has failed to ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident behavior, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:

A CI was submitted to the Director regarding an allegation of abuse of a resident by another resident who sustained an alteration in skin integrity.

A resident was known to exhibit behaviors of physical aggression towards co-residents.

On a specific date, a Dementia Observation Tool (DOS) Assessment was initiated and concluded five days later. During the DOS assessment period, it revealed forty incidents of physical aggression towards staff and co-residents.

A request was made for a consultation with a specialized external service on a specified date. At that time, the consultants reviewed the resident's medication regimen and made changes based on their condition. The NP made a plan to adjust

the timing of the medication. The Behavioral Support Ontario (BSO) team at the home was to continue to monitor the resident.

On a specified date, the Doctor wrote a progress note to indicate that a scheduled medication dose was the current plan for a resident and the effectiveness of nonpharmacological interventions was minimal.

On a specified date, a meeting was held by the home and the consultant geriatrician, who recommended a change in the timing of a specific medication.

On a specified date, the NP assessed the latest DOS and noted that behaviors were still occurring in the day and added another medication whenever the resident needed this medication, and at the same time discontinued the use of another medication. There was no further follow-up to this plan by the NP.

On a specific date, the resident was discharged from the specialized external service, despite the resident's daily documented behaviors towards other residents in the progress notes.

Interviews with BSO RPN, RN, RCC, and DOC confirmed that they were unaware that the interventions were documented as ineffective. Interviews with BSO RPN, RN, RCC, DOC, and NP confirmed they were unaware of the numerous documented progress notes of the allegations of physical and verbal abuse that was occurring towards other co-residents.

The licensee put a resident at risk of harm when they failed to ensure that, procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Sources: CI Report, progress notes and care plan of a resident, interviews with staff.

[741755]

This order must be complied with by August 30, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the

order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.