Ontario

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: November 29, 2024
Original Report Issue Date: November 14, 2024
Inspection Number: 2024-1625-0003 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Terraces, Oshawa

AMENDED INSPECTION SUMMARY

This report has been amended to:
Non-compliance #004 was amended to reflect the accurate date the Director was informed of the incident. Compliance Order #001 is included in this report for reference; however, was not amended; therefore, the date issued remains November 14, 2024.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-25, 28-31 and November 4, 2024
The inspection occurred offsite on the following date(s): November 1, 2024
The following intake(s) were inspected:

- Intake: #00117885 - Disease outbreak.

- Intake: #00118188 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) CDD August 30, 2024.
- Intake: #00118189 - Follow-up #: 1 - O. Reg. 246/22 - s. 60 (a) CDD August 30, 2024.
- Intake: #00120676 - Unexpected death of a resident.
- Intake: #00123439 - Improper/incompetent care of a resident.
- Intake: #00124088 - Complainant related to treatment and skin and wound.
- Intake: #00126409 - Complainant related to skin and wound, nail care, bathing, call bell and privacy.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1625-0002 related to FLTCA, 2021, s. 24 (1) inspected by the Inspector.

Order #002 from Inspection #2024-1625-0002 related to O. Reg. 246/22, s. 60 (a) inspected by the Inspector.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that the resident plan of care was reviewed and revised when the care set out in the plan had not been effective.

Rationale and Summary:

The Long-Term Care Home (LTCH) submitted a Critical Incident Report (CIR) regarding a complaint of alleged neglect of a resident. The Ministry of Long-Term Care (MLTC) received a complaint about the same allegation.

A resident returned to the home and developed a change in condition. The resident was assessed by the Nurse Practitioner (NP) and a treatment was ordered. The resident was reassessed and additional treatments were ordered and completed. The resident's condition continued to persist, and an additional assessment concluded that their condition worsened. A referral was completed and confirmed the resident's condition. The resident was then treated with multiple interventions.

Registered staff confirmed that residents are to be reassessed by the nurse until conditions have resolved. Further if a resident's condition has worsened or remains

unchanged the nurse is to refer back to the team to determine if a different approach is needed. The Administrator acknowledged that if the nurse noted that the resident's condition had worsened, they should have referred to the NP or physician for reassessment at the time of the change.

Nursing staff noted that the resident's condition had worsened, and they did not report this change to the NP or physician. This may have led to a delay in diagnose and treatment of the resident.

Sources: Resident's clinical record, interviews with registered staff, the Administrator and others.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that registered staff reassessed the resident's skin weekly.

Rationale and Summary:

A compliant was received to the Director related to concerns of skin and wound

care management.

A review of the resident's clinical records indicated missing assessments for several altered skin integrities, during a number of weeks.

Registered staff confirmed that staff had not documented assessments for the resident. Registered staff also clarified that the expectation for registered staff is to document skin and wound assessments.

During an interview with Skin and Wound Clinical Lead, confirmed registered staff were expected to document assessments for the resident and acknowledged that registered staff had not documented assessments.

Failing to ensure that the resident received assessments, placed the resident at an increased risk of skin breakdown and prevented staff from monitoring skin integrity, risk of infections and pain.

Sources: Resident's clinical records, Skin and Wound Care Program Policy and interview with registered staff and Skin and Wound Clinical Lead.

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to use proper techniques to assist residents with eating.

Rationale and Summary:

During an onsite inspection, a staff member was observed feeding two residents intermittently while standing during a meal service. The residents were not coughing or showing any discomfort.

Record reviews revealed that both residents were enrolled in the therapeutic dining program facilitated by staff or Occupational Therapist (OT) during meals. A resident was at moderate nutritional risk and another resident was at high nutritional risk.

According to a protocol, staff should be seated at the resident's eye level and off to one side.

Separate interviews with the staff member and the Registered Dietitian (RD), acknowledged that the staff member was not sitting down next to the residents and positioned at their eye level when providing feeding assistance to minimize risk of choking.

Failing to use proper techniques to assist the residents with eating increases the risk of choking and negative health outcomes.

Sources: Observations, residents' record reviews, protocol, and interviews with the staff member and RD.

(A1)
The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: Reporting re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to report the Director using the Ministry's after hours emergency contact when the resident died unexpectedly after business hours.

Rationale and Summary:

A CIR was submitted to the Director about the unexpected death of the resident.

The Director was not immediately informed when the incident occurred.

Separate interviews with registered staff and Director of Care (DOC) confirmed that the staff did not use the Ministry's after hours emergency contact to notify the unexpected death of the resident.

Sources: CIR, interviews with registered staff and DOC.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) The IPAC Lead or designate shall provide in-person education for PSW #107, PSW #108 and Maintenance Worker #122 on the home's routine practices and additional precautions polices, including but not limited to the four moments of hand hygiene and donning and doffing techniques.
2) Document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that completed the education session.
3) The IPAC Lead or designate shall conduct weekly hand hygiene audits, over the course of four weeks, for each of the following staff: PSW #107, PSW #108 and Maintenance Worker #122. The audits shall include the individual completing the audit and any corrective actions taken if staff do not comply with the four moments of hand hygiene and donning and doffing techniques.
4) Keep records of the completed audits and make them available to the inspector immediately upon request.

Grounds:

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee failed to ensure that staff were completing hand hygiene before and after interactions with residents and after doffing Personal Protective Equipment (PPE).

The home failed to ensure that section 9.1 b) of the IPAC Standard for Long-Term Care Homes April 2022, revised in September 2023 was met. Section 9.1 b) of the standard states “the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);”

Rationale and Summary:

Personal Support Worker (PSW) #107 assisted a resident in their wheelchair into a resident lounge area. PSW #107 was then observed assisting another resident in their wheelchair without performing hand hygiene before or after both resident interactions. PSW #107 verified that the unit was in a confirmed outbreak and that hand hygiene should have been completed after and prior to interacting with another resident.

PSW #108 assisted a resident in their wheelchair into the home’s resident lounge area. PSW #108 proceeded to assist another resident in a wheelchair without performing hand hygiene. PSW #108 acknowledged that they should have

completed hand hygiene after interacting with the initial resident and before moving on to assist the next resident. PSW #108 confirmed that the unit was in a confirmed outbreak.

An interview with IPAC Lead confirmed staff were expected to clean their hands before and after interacting with residents.

Maintenance Worker #122 was observed doffing PPE after leaving a home area. After disposing their gown, Maintenance Worker #122 was seen not completing hand hygiene. In an interview, Maintenance Worker #122 confirmed that unit was on a confirmed outbreak and that hand hygiene was to be completed after removing their gown.

Failure to ensure hand hygiene before and after resident interactions, and after doffing PPE increased the risk of spreading infectious agents.

Sources: Observation on October 23, 24, and 31, 2024, Hand Hygiene Program Policy and interview with IPAC Lead.

This order must be complied with by January 10, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Non-compliance history for O. Reg. 246/22, s. 102 (2) (b):
Inspection #2024-1625-0001 - Compliance Order High Priority issued February 23, 2024.
Inspection #2022-1625-0001 - Written Notification issued June 9, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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

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.