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

Public Report

Report Issue Date: July 17, 2025

Inspection Number: 2025-1625-0004

Inspection Type:
Critical Incident

Licensee: Regional Municipality of Durham

Long Term Care Home and City: Hillsdale Terraces, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9-11 and July 15-17, 2025
The inspection occurred offsite on the following date(s): July 14, 2025

The following intake(s) were inspected:

- Two intakes related to sexual abuse of a resident by a co-resident.
- One intake related to the home's infection prevention and control program.
- One intake related to a missing resident.

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

Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee failed to ensure a resident was supervised while outside on the resident patio area. Video footage showed the resident unsupervised on the outdoor patio and subsequently eloped by climbing over a fence. The resident was later found away from the long-term care home (LTCH). The doors to the patio door was unlocked, and no staff supervision was observed at the time of the incident. The Director of Care (DOC) acknowledged the resident should have been supervised while on the patio.

Sources: Video Footage, Critical incident report. and interview with DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that section 9.1 (f) of the Infection Prevention and Control (IPAC) Standard was accurately followed. When a Registered Practical Nurse (RPN) exited a resident's room under contact precautions and entered the TV area while still wearing the same gown and gloves. The IPAC Lead acknowledged this was a violation of the home's IPAC program.

Source: Home's IPAC Program, observation of RPN, interviews with the RPN and IPAC Lead.

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