

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: September 5, 2025

Inspection Number: 2025-1625-0005

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): August 13 to 15, 18 to 22, 25, 26, and September 2 to 5, 2025.

The following intake(s) were inspected:

- Intake: #00152704 - related to an outbreak.
- Intake: #00154472 - related to resident to resident sexual abuse.
- Intake: #00154738 - related to resident to resident emotional abuse.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

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(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident. The Director of Care (DOC) and a Personal Support Worker (PSW) confirmed that there were no resident specific written instructions for the staff who were assigned 1 to 1 monitoring of a resident. A Registered Practical Nurse (RPN) and the Behavioural Supports Ontario Personal Support Worker (BSO PSW) had two different interpretations of what a specific care plan intervention meant, and the 1 to 1 monitoring intervention was not added to the resident's care plan until eight days after being initiated.

Sources: resident clinical records, PSW, RPN, BSO PSW, and DOC interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 a resident was reassessed and the plan of care reviewed and revised, when the intervention of 1 to 1 monitoring had been ineffective in the days leading up to an abusive altercation towards another resident on a specific date. Incident documentation and the PSW interview confirmed that staff were unable to intervene with the specified intervention when the residents behavior turned, requiring them to remove the other resident from the area. The Director of Care (DOC) confirmed that the 1 to 1 monitoring intervention had been ineffective, as there had been a history of harm to other residents while it was in place, noting that there needed to be further intervention.

Sources: resident clinical records, 1 to 1 Documentation records, PSW and DOC interview.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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NC #003 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.

On a specified date when one resident was suspected to have abused another resident, the incident was not reported to the Director until the evening of the next day. The reporting Registered Practical Nurse (RPN) was initially told by the Registered Nurse (RN) that it was not a critical incident and to document in a behaviour note, and the next day they were informed to complete a critical incident report, as per management direction. The Director of Care (DOC) confirmed it should have been reported immediately.

Sources: critical incident report, RPN and DOC interviews.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. 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,

(b) identifying and implementing interventions.

The licensee failed to implement interventions to minimize altercations between two residents, when one of them exhibited allegedly abusive behaviour towards the other, on a specified date. Staff interviews, progress notes, and a 1 to 1 documentation form, confirmed that close 1 to 1 monitoring was initiated with the intent of re-directing the resident's attention away from the other resident, however, staff were unable to execute the intervention, resulting in ongoing incidents of alleged abusive behaviours towards the same resident.

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Sources: resident clinical records, PSW, RPN, BSO PSW, and DOC interviews.

COMPLIANCE ORDER CO #001 Housekeeping

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

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

The licensee shall ensure that:

- 1) The home's Environmental Services (ES) Department and IPAC Practitioner (ICP) meet collaboratively to review the general disinfectant products used in the home and discontinue the use of redundant products (if any), keeping a record of the meetings and/or discussions, dates/actions taken, and resulting list of approved general disinfectant products.
- 2.) The ES Department posts a list of the approved general disinfectant products including corresponding contact times and intended uses, on every resident care unit and any other appropriate location for quick staff reference.
- 3) The ES Department notifies all staff who use the general disinfectant products about the results of the product review, including at minimum: any changes that were made (if applicable), who to call with questions, and where to find the posted listed of approved general disinfectant products and their uses.
- 4) The ES Supervisor or trained delegate provides in-person training to ES #108 regarding at minimum the following topics: compliance with disinfectant contact (dwell) times as per the homes approved general disinfectant list, and the proper use of each disinfectant as per the manufacturer's instructions and home's cleaning policies (for example: use at recommended concentration, do not dilute with tap water). Keep a

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record of the training date, content, and the signatures of the trainer and trainee, confirming completion and understanding of the training.

Grounds

The licensee failed to ensure that procedures were implemented for cleaning and disinfection of contact surfaces in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, when an ES worker rinsed the disinfectant from the bathroom sink, prior to the recommended contact time, and diluted the disinfectant on the microfibre cloth, and wrung it out before cleaning the toilet. The ES Supervisor confirmed they wouldn't be getting the kill/dwell time.

Sources: resident bathroom cleaning observation, staff interviews (ES worker and Supervisor).

This order must be complied with by November 14, 2025

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #006 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 ensure that:

1) The Infection Prevention and Control Practitioner (ICP) or trained delegate provides in-person training regarding the appropriate use of personal protective equipment (PPE) to the following staff: Environmental Services worker (ES) #108, Personal Support Workers (PSWs) #106, #107 and #110, and Physiotherapy Assistant (PTA) #112.

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- 2) The PPE training above will include, at minimum, the following topics: the importance of reading and following additional precautions signage, appropriate PPE storage locations (not in pockets), when and how to apply, remove and dispose of PPE, and how to prevent contamination of clean areas/surfaces from soiled PPE. Keep a record of the training content, date, including the trainer and trainee signatures confirming completion and understanding
- 3) The ICP invites front-line nursing department staff (personal support workers and registered staff) to form an advisory committee that will meet to explore the reason for storing gloves in pockets, identify issues/barriers to easily accessing PPE supplies, and together develop and implement a plan to improve staff accessibility of PPE supplies on Rose Garden unit.
- 4) The ES Department halts the use of a shared toilet brush on the Rose Garden unit, developing and implementing a new process that prevents carrying one brush from room-to-room.
- 5) The ICP develops and implements a process for ensuring that the additional precautions resident doorway signage for all residents requiring additional precautions, matches the current additional precautions ordered by the Medical Officer of Health/Public Health Department, or the table found in Appendix N: Clinical Syndromes/Conditions with Required Level of Precautions of the PIDAC: Routine Practices and Additional Precautions in All Health Care Settings | June 2025 document.
- 6) The ES Supervisor or trained delegate provides in-person training to ES #108 about what steps need to be taken when refraining from using contaminated equipment between resident rooms, such as: mop handles/heads, microfibre cloths, and toilet brush. Keep a record of the training content, date, including the trainer and trainee signatures confirming completion and understanding.

Grounds

1. The licensee failed to ensure that a standard issued by the Director with respect to Infection Prevention and Control (IPAC), in accordance with Section 9.1 under the IPAC Standard for Long-Term Care Homes (Sept 2023), when at minimum, Additional Precautions shall include: f) Additional PPE requirements including appropriate selection, application, removal and disposal.

An ES worker contaminated the housekeeping cart with soiled gloves, and the ES Supervisor confirmed that performance of a glove change with hand hygiene was required before accessing the cart.

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Three personal support workers (PSWs) were observed storing gloves in their pockets, a practice discouraged by the ICP but acknowledged to be a common practice home wide.

A PTA entered a resident room on Rose Garden unit, passing by additional precautions signage indicating full PPE was required, and proceeded to assist the resident wearing gloves only. The ICP confirmed gown and gloves were required.

By failing to properly select, apply, remove, and dispose of PPE, the licensee contributed to the chain of transmission, during a time of uncontrolled spread of an undiagnosed medical condition, that was causing discomfort to the residents.

Sources: Rose Garden unit PPE use observations, staff interviews (two PSWs, ES worker, ES Supervisor, and ICP).

2. The licensee failed to ensure that a standard issued by the Director with respect to Infection Prevention and Control (IPAC), in accordance with Section 9.1 under the IPAC Standard for Long-Term Care Homes (Sept 2023), when at minimum, Additional Precautions shall include: e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

Despite Public Health direction to place residents with a specific medical condition or those undergoing treatment on contact precautions, incorrect additional precautions signage continued to be posted on the resident room doorways two days later. An RPN incorrectly described to a PTA what PPE was required to care for a resident on the Rose Garden unit. The ICP confirmed the signage was incorrect and later changed it.

By causing confusion when posting incorrect additional precautions signage, the licensee contributed to the chain of transmission, during a time of an uncontrolled medical condition, that was causing discomfort to the residents.

Sources: additional precautions signage observations, staff interviews (PTA, RPN, and ICP).

3. The licensee failed to ensure that a standard issued by the Director with respect to Infection Prevention and Control (IPAC), in accordance with Section 9.1 under the IPAC

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Standard for Long-Term Care Homes (Sept 2023), when at minimum, Routine Precautions shall include: e) Use of controls, including: i. Environmental controls, including but not limited to, location/placement of residents' equipment.

An ES worker confirmed the use of contaminated cleaning equipment between resident rooms. The provincial best practice document and the ES Supervisor acknowledged that contaminated supplies/equipment should not be taken from room to room.

By sharing contaminated cleaning equipment between resident rooms, the licensee contributed to the chain of transmission, during a time of an uncontrolled medical condition, that was causing discomfort to the residents.

Sources: cleaning equipment/cart observations, page 62 'PIDAC: Best Practices for Environmental Cleaning in All Health Care Settings, 3rd Edition' April 2018, staff interviews (ES worker and Supervisor).

This order must be complied with by November 14, 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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$11000.00, 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:

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2025-1625-0004 – WN issued 2025-07-17
2025-1625-0001 - WN Issued 2025-01-22
2024-1625-0003 - CO issued 2024-11-14 with AMP \$5,500
2024-1625-0001 - CO (HP) issued 2024-02-23

This is the second 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.

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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

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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.



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

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