

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 5, 2025
Original Report Issue Date: September 5, 2025
Inspection Number: 2025-1625-0005 (A1)
Inspection Type: Critical Incident
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Terraces, Oshawa

AMENDED INSPECTION SUMMARY

This report has been amended to:
A Director's review was completed and the Director's decision was issued on October 30, 2025, to rescind Compliance Order (CO) #001, as well as, rescind and substitute CO #002 with a Director's Order.

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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:

- an intake related to an outbreak.
- an intake related to resident-to-resident sexual abuse.
- an intake 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

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 (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,

(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, staff 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 specified date. Incident documentation and the PSW interview confirmed that staff were unable to intervene with the specified intervention when the resident's behaviour turned, requiring

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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, staff interviews.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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, staff 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.

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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.

Sources: resident clinical records, staff interviews.

(A1) Appeal/DREV #: DREV-0062

The following order(s) has been rescinded: CO #001

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;

(A1) Appeal/DREV #: DREV-0062

The following order(s) has been rescinded: CO #002

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).

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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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