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: December 8, 2025
Inspection Number: 2025-1625-0007
Inspection Type:
Complaint
Critical Incident
Director Order Follow Up (DOFU)

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): November 18 - 20, 24 - 27, 2025 and December 1, 4, 2025
The inspection occurred offsite on the following date(s): November 28, 2025 and December 2, 3, 2025
The following intake(s) were inspected:

- four intakes related to missing controlled substance
- intake of allegation of emotional abuse
- intake of a complaint allegation of neglect
- intake of allegation of financial abuse
- Intake related to follow up of DOFU #: 1 - O. Reg. 246/22, s. 102 (2) (b)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Director Order #001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident was not provided opportunity to participate in the development and implementation of their plan of care related to their personal care preferences**.**

Sources: resident's clinical records, home's investigation notes and interviews with resident and staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

1.The plan of care for a resident regarding pain and medication management was not updated to reflect their current needs.
Sources: Resident's clinical health records, Pain Management Policy, and interviews with staff,

2.The plan of care for a resident regarding pain and medication management was not updated to reflect their current needs.

Sources: resident's clinical records, Pain Management Policy, and interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 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.

A Resident had personal items removed from their closet without the knowledge or consent of the resident's substitute decision maker (SDM) which resulted in financial abuse of the resident.

Sources: Critical incident report (CIR), home's internal investigation file, resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

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:

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10

business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

A verbal complaint from a resident's substitute decision maker (SDM) was received by the licensee on a specified date. At the time of inspection, there was no documentation indicating that resident's SDM had been contacted by the home to acknowledge receipt of the complaint, documentation of the date by which the complainant could reasonably expect a resolution, and a follow-up response.

Sources: CIR, resident's clinical record, the home's Management of Complaints Policy and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

3. A missing or unaccounted for controlled substance.

A controlled substance was noted and reported by staff to another staff member as missing for a resident on a specified date. The missing controlled substance was not reported as a Critical Incident within one business day.

Sources: CIR, resident's clinical record, Medication Incident Report, home's Monitored Medications Policy and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (5)

Reports re critical incidents

s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

2. A description of the individuals involved in the incident, including,

i. names of any residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 246/22, s. 115 (5).

A critical incident for missing uncontrolled substance was reported to after hours as occurring on a specified date but the written report required was not submitted to the Director until 17 days later.

Sources: CIR and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

On a specified date, a resident was found to have a medication administered to them that was not prescribed for the resident.

Sources: CIR and interviews with staff.

COMPLIANCE ORDER CO #001 Pain management

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Hold interdisciplinary meetings for the specified residents to review and update their plans of care related to pain management to provide clear interventions to assess, and manage their pain, and the process of how to monitor the effectiveness of their pain management. The plans of care should indicate when pain screening and comprehensive pain assessments are required.
2. Educate staff on each resident's specified home area regarding their updated plans of care for pain management.
3.Keep a documented record of the interdisciplinary meetings, updated plans of care and education of staff.
4.Conduct weekly audits for four weeks of the specified resident's pain management to ensure staff complete pain screening and comprehensive pain assessments as required in their plan of care , and to assess the residents pain management program is effective. Keep a documented record of the weekly audits.

1.The pain management program was not implemented effectively for a resident when their controlled substance was missing, and when pain was identified.

Grounds
The home's policy for controlled substances requires careful monitoring for pain levels and adverse events. The pain management policy requires screening for pain following a change in clinical status using the home's Comprehensive Pain Assessment.

On two specified dates a resident's controlled substance was found missing. A comprehensive pain assessment was not completed on the specified date, and was delayed until the day after the patch was reapplied.

Clinical health records for the resident show PRN (as needed) pain medication was administered when routine pain management was not effective on multiple dates, and pain levels were documented frequently. Comprehensive pain assessments were completed only on four specified dates and were listed as triggered by other

assessments rather than missing patches or uncontrolled pain.

Interviews revealed inconsistent monitoring practices: Staff reported the resident appeared in great pain and resisted care. Another staff member stated the resident has a specified medical diagnosis and is always in pain, requiring frequent PRN medication, while other staff did not administer PRNs as often. The Pain Lead acknowledged that comprehensive pain assessments should occur when pain is not relieved by PRN medication and confirmed the home lacked a process to evaluate the controlled substance effectiveness beyond weekly pain rounds. Staff confirmed the home should have completed a comprehensive pain assessment when the resident's controlled substance was missing.

Not completing timely pain assessments when a controlled substance is missing, or pain is identified, posed a risk to a resident of unrelieved pain and inadequate pain control.

Sources: two CIR, resident's clinical health records, Pain Management Policy, High Alert Mediation Policy and interviews with staff.

2.The pain management program was not implemented effectively for a resident when their controlled substance was missing, and to identify if their pain management was effective.

Grounds
On a specified date, a resident's controlled substance was reported missing. No pain assessment was completed at that time. Staff found what they believed was the resident's controlled substance. On the following day, staff realized the controlled substance was not the one prescribed for the resident. A new order for a controlled substance was obtained for the resident. A pain assessment was completed in the afternoon after the new patch was applied.

Review of documentation shows that the home has completed only one comprehensive pain assessment for resident the in five years, which was on a specified date. There is no documentation indicating how the home monitors the effectiveness of the resident's pain management on their controlled substance.

Not completing timely pain assessments when a controlled substance was missing or

replaced for a resident posed a risk of unmanaged pain, delayed intervention, and reduced quality of life.

Sources: CIR, resident's clinical health records, Pain Management Policy, High Alert Medication Policy and interviews with staff.

This order must be complied with by February 27, 2026

COMPLIANCE ORDER CO #002 Medication management system

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall
1.Hold interdisciplinary meetings to review and update the plans of care for the specified residents related to medication management to meet their current needs and provide for safe medication management and optimized drug therapy. The review should include directions for safe management and monitoring of the resident's controlled substance for both registered and non-registered staff.
2. Educate staff on each resident's specified home area regarding their updated plans of care for medication management.
3.Keep a documented record of the interdisciplinary meetings, updated plans of care and education of staff.
4.Conduct daily audits for two weeks of the specified resident's controlled substance to ensure compliance with policy and their plans of care. The audit is to include:
a. Visual verification that the controlled substance is present, labeled and administered correctly.
b. Documentation reviewed that it includes two nurses have monitored the controlled substance together, at the correct time and documented the location of controlled substance.
c. Documentation on the EMAR/ETAR and controlled substance monitoring form has

been completed correctly.
d. Education of staff for any inconsistencies found during monitoring
e. Keep a copy of the audit including time and date, who completed the audit, areas audited, any inconsistencies found, and name of staff educated if applicable.
5.Provide retraining / education to a specified staff member specifically concerning safe medication administration including a review of the home's Medication Administration Program and the Monitored Medication Program. Keep a copy of the training records, including date, time and training content.

Grounds
1.A discrepancy in the controlled substance count for a resident's controlled substance dose was identified on a specified date by staff . Recordings on the medication count sheet for the controlled substance for the period of specified dates indicated that it had been altered by staff. The missing dose of the controlled substance had not been located or accounted for at the time of the inspection.

Sources: Critical Incident Report , resident's clinical record, Medication Incident Report, home's Monitored Medications Policy, and interview with staff.

2.The medication management system did not provide safe medication management and optimized effective drug therapy outcomes for two specified residents.

Grounds
On three specified dates, the home submitted critical incident reports (CIR) for missing controlled substances.

The home's policies require monitoring and documenting the presence of controlled substances each shift and provide direction of actions to take when a controlled substance is missing.

On a specified date a, resident's controlled substance was reported missing between monitoring. A search was unable to find the missing controlled substance despite staff confirming the resident is non ambulatory and unable to dispose of the controlled substance themselves.

On a specified date, a resident was reported to have a missing controlled substance and after a search the staff found and it and readministered the controlled substance.

On the following day, the controlled substance for the resident was identified to be the wrong controlled substance. Staff indicated the home's policy was that a missing controlled substance was to be reported immediately, the doctor called, and orders received for a new controlled substance. Furthermore, the home acknowledged that staff did not follow the home's policies for medication management.

On a specified date, documentation indicates that nursing staff on days and evenings did not follow policy to have two nurses check together to monitor a specified controlled substance for a resident. Interviews confirmed staff did not consistently follow monitoring protocols and identity verification standards.

The home's investigations acknowledged breaches of medication management policies and documentation requirements, and staff were disciplined and re-educated.

When the medication management system did not provide safe medication management for the controlled substances for two specified residents this posed a risk of unmanaged pain, medication errors, and potential diversion of controlled substances.

Sources: Three CIR**,** home's investigation notes, High Alert Mediation Policy, Medication Administration Program Policy, Monitored medications Policy, resident's clinical health records, and interviews with staff.

This order must be complied with by February 27, 2026

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.