Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 4, 2026
Inspection Number: 2026-1625-0001
Inspection Type: Complaint 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 dates: January 28-30, 2026 and February 2-4, 2026.

The following intakes were inspected:

-Two intakes related to fall.
-One intake related to an outbreak.
-Two intakes related to allegation of neglect/ abuse.
-One complaint Intake related to allegation of abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

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Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a fall involving a resident. The resident fell from their bed, sustaining fractures.

The resident reported that after the Personal Support Worker (PSW) left the room to get assistance, the resident slipped out of bed and stated that the bed was not locked at the time of the incident. The resident's clinical record including their plan of care indicated that the resident's bed was required to remain in a locked position for safety.

Sources: Clinical records , Long Term Care Home (LTCH) investigation Notes.