

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	_	Type of Inspection / Genre d'inspection
Mar 31, 2014	2014_270531_0005	000865- 13/000927	Critical Incident System

#### Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3

## Long-Term Care Home/Foyer de soins de longue durée

HILLSDALE TERRACES

600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

## Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs SUSAN DONNAN (531)

## Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15th and 16th, 2014

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Practical Nurses, Registered Nurse, Resident Care Coordinator, Physiotherapist, Director of Care and Administrator.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health records including external consult records.

The following Inspection Protocols were used during this inspection:



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## Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES			
Legend	Legendé		
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités		
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.		
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non- respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.		



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WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports recritical incidents

Specifically failed to comply with the following:

- s. 107. (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 (4):
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

## Findings/Faits saillants:

1. the licensee has failed to comply with O.Reg 79/10s. 107(3)4 in that the licensee failed to report an injury for which the person is taken to hospital to the Director in one business day.

On an identified date Resident #2 sustained an injury while being transferred using a Pivot device requiring transfer to hospital.

The injury for which Resident #2 was taken to hospital was not reported to the Director within one business day.

Issued on this 31st day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs