Ontario

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 4, 2014	2014_280541_0008	O-000717-13	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

AMBER MOASE (541)

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 31 and April 1, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Resident Care Coordinator, a Registered Nurse, a Registered Practical Nurse, a Housekeeper and a Food Service Worker.

During the course of the inspection, the inspector(s) reviewed the licensee's investigation files, reviewed resident health care records, observed staff to resident interactions and reviewed the licensee's policy ADM-01-05-01 Abuse and Neglect - Prevention, Reporting and investigation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007 c.8 s. 24(1) whereby the licensee did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

According to the Critical Incident report M630-000053-13 an incident of alleged abuse was witnessed by staff #S104 on an identified date in November 2013 and staff #S104 did not report this to the home until 10 days later. [s. 24. (1)]

2. As per Critical Incident report M630-000053-13, on an identified date in November 2013 staff #S104 reported to the home an alleged incident of abuse of resident #3 whereby staff #S105 spoke in a loud manner towards resident #3 that was indicative of verbal/emotional abuse.

Review of Critical Incident M630-000053-13 and the licensee's investigation files indicates this incident was first reported to the Director 2 days after the home became aware of the incident. A discussion with staff #S102 indicates it was the expectation the Director would have been notified on the day of the incident.

The licensee failed to immediately report the incident of alleged abuse to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all persons who have reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007 c.8 s. 20(2)(h) in that the policy to promote zero tolerance of abuse and neglect of residents does not deal with any additional matters as may be provided in the regulations, specifically O.Reg 79/10 s.97(1)(a).
O.Reg 79/10 s.97(1)(a) states that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Policy ADM-01-0501 Abuse and Neglect - Prevention, Reporting and Investigation was provided by the home's administrator and is the licensee's policy to promote zero tolerance of abuse and neglect.

A review of policy ADM-01-0501 demonstrates the following:
1. Reporting requirements direct staff to "Ensure that the family member/SDM/POA has been notified of the incident as soon as possible but within 12 hours."

The policy does not indicate when the SDM must be contacted immediately as defined in O.Reg 79/10 s.97(1)(a). [s. 20. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10(1)(a) whereby the resident's SDM and any other person specified by the resident were not immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

As per an interview with staff #S100 and review of the critical incident report, on an identified date in July 2013, staff #S106 witnessed staff #S107 slap resident #1 on the arm. As a result of this incident resident #1 sustained a visible physical injury.

An interview with staff #S102 indicates the incident described above would be defined as alleged physical abuse.

A review of the licensee's Resident Abuse Allegation Report states the SDM for resident #1 was notified on the morning following the incident. An interview with staff #S100 and #S102 indicate the expectation was that the SDM would have been notified that same night. [s. 97. (1) (a)]

2. On a date in November 2013 staff #S108 was witnessed providing care to resident #2 when staff #S109 overheard resident #2 yell out indicating he/she was in pain. S109 then witnessed S108 pull on resident #2's arm while trying to turn the resident to finish care.

A review of the home's investigation records indicate resident #2's SDM was first notified 12 hours after the incident occurred. The licensee failed to immediately notify resident #2's SDM upon becoming aware of the witnessed incident of abuse that resulted in pain to the resident. [s. 97. (1) (a)]

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Issued on this 15th day of April, 2014

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