Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 16, 2010	2010_166_9630_13Aug142955	Critical Incident- line 272 History Log

Licensee/Titulaire
Regional Municipality of Durham , 905-668-7711 Fax 905-668-1567
605 Rossland Road East Whitby,
ON K9A 4G7

Long-Term Care Home/Foyer de soins de longue durée
Hillsdale Terraces, 905-579-3313 Fax 905-579- 4420
600 Oshawa Blvd. North
Oshawa,ON
L1G 5T9

Name of Inspector(s)/Nom de l'inspecteur(s)
Caroline Tompkins # 166 , Patricia Powers # 157

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspectors spoke with the Assistant Administrator, Director of Care, Environmental Services Manager, 2 Registered Nursing staff who work on the second floor and 3 Personal Service Workers who also work on the second floor.

During the course of the inspection, the inspectors observed the exit door that malfunctioned resulting in this Critical Incident, the inspectors reviewed the home's investigation report, the resident's plan of care related to safety needs, the resident's progress notes related to the incident of June 17, 2010.

Findings of Non-Compliance were found during this inspection.

The Licensee has failed to comply with the Long Term Care Homes Program Manual:
B3.16 Each resident's environment shall be maintained to minimize safety and security risks. Actions shall be taken to protect each resident from identified potential hazardous substances, conditions and equipment.

Findings:
The Environmental Service manager of the home on the day of the incident determined that the cause of the malfunction was a slight warp in the door that caused the magnetic lock to be disengaged. When the cause of the malfunction was identified corrective action took place immediately.

Inspector ID #:	#166, #157

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). October 7 2010