Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2019	2019_598570_0012	000117-18, 002470-18, 004251-18, 006998-18, 007509-18, 007859-18, 009426-18, 012058-18, 017363-18, 018945-18, 021231-18, 026117-18, 028399-18, 031011-18, 001369-19, 008322-19, 008528-19	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 Estates
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

SAMI JAROUR (570), JENNIFER BATTEN (672), PATRICIA MATA (571)

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): May 16, 17, 21-24, 27-31, June 3-7, 10-14 and 19, 2019

The following logs related to Critical Incident Reports (CIR) were included during this inspection:
- Log #000117-18, related to resident to resident alleged abuse
- Log #002470-18, related to resident to resident alleged abuse
- Log #004251-18, related to staff to resident alleged abuse
- Log #006998-18, related to an outbreak
- Log #007509-18, related to resident to resident alleged abuse
- Log #007859-18, related to allegation of abuse
- Log #009426-18, related to an outbreak
- Log #012058-18, related to an outbreak
- Log #017363-18, related to an injury of unknown cause
- Log #018945-18, related to improper care of a resident resulting in an injury
- Log #021231-18, related to an allegation of improper care and injury of unknown cause
- Log #026117-18, related to staff to resident alleged abuse
- Log #028399-18, related to staff to resident alleged abuse
- Log #031011-18, related to resident to resident alleged abuse
- Log #001369-19, related to a fall of a resident resulting in an injury
- Log #008322-19, related to resident to resident alleged abuse and
- Log #008528-19, related to resident to resident alleged abuse

PLEASE NOTE: The following two non-compliance were identified and issued in complaints inspection report #2019_715672_0005 that was conducted concurrently with this inspection:
Non-compliance with the LTCHA, 2007, s. 24. (1) related to late reporting of an allegation of resident to resident abuse.
Non-compliance with O.Reg 79/10, s. 52 (2) related to pain assessments not completed using a clinically appropriate assessment instrument specifically designed for this purpose.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Family members, Resident Care Coordinators (RCC), Infection Control Nurse, Behavioural Ontario Support (BSO) RPN and PSWs, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support

Workers (PSW), Physician, Physiotherapist, non clinical Nurse Manager, MDS RAI coordinator, and recreation staff.

During the course of this inspection, the Inspectors, toured specific resident rooms and common residents' areas, observed residents to residents interactions and staff to residents interactions, reviewed clinical records, relevant policies to this inspection, the licensee's investigations documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Related to Log #004251-18:

A review of Critical Incident Report (CIR), submitted to the Director on specified date, revealed that RPN #180 had posted resident #013's photo on social media.

A review of the home's investigation indicated that RPN #180 failed to follow the home's policies and procedures in regards to the incident involving resident #013.

During an interview with RPN #180, they acknowledged they posted the resident's photo on social media without talking to the resident or their Substitute Decision Maker (SDM).

During an interview with resident care coordinator (RCC) #105, they indicated to Inspector #570, that RPN #180's actions were a breach of confidentiality and emotional abuse.

During an interview with the Director of Care (DOC), they confirmed that the posting of the picture was a violation of resident's right to be treated with respect and dignity.

The licensee has failed to ensure that resident #013's rights were respected when RPN #180 had altered and posted resident's photo on social media without the resident's or their SDM's consent. [s. 3. (1) 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 every resident at the home is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #001.

Related to Log #018945-18:

A review of Critical Incident Report (CIR), submitted to the Director on specified date, indicated that on a specified date resident #001's identified body part rolled under a mobility device in a reclined position while being pushed by staff and the resident complained of discomfort. The resident was transferred to hospital on a specified due to increased pain and swelling to the identified body part and was diagnosed with an injury to the identified body part.

A review of resident #001's progress notes indicated:
- On identified date and time, PSW staff reported that resident #001's identified body part rolled under a mobility device. The resident complained of discomfort.
- On identified date and time, RN #119 assessed resident #001 and noted that resident #001's identified body part was swollen, warm to touch and the resident complained of pain when touched. The resident was assessed by the physician and the resident was transferred to hospital.
- On identified date and time, the resident returned to the home with a confirmed diagnosis of an injury to the identified body part.

During an interview, PSW #107 confirmed that resident #001 required total care. PSW #107 indicated that on the date of the incident, resident #001 was using a mobility device which was reclined when being pushed, the resident leaned forward and the resident's identified body part was bent under the mobility device. The resident complained of pain. RPN #106 was informed and assessed the resident. The PSW further indicated that after a couple of days, the resident's identified body part was swollen and had a confirmed injury.

During an interview, RCC #105 indicated that PSW #107 stated that resident #001's identified body part was dropped in and around the mobility device. The RCC indicated that the incident was investigated and concluded that PSW #107 did not ensure the identified body part was supported while the resident was being pushed causing the resident's body part to drop.

During an interview, the DOC indicated that PSW staff should be supporting resident's identified body when transporting the resident using a specified mobility device. The DOC further indicated that staff in the home area, where resident #001 resided, received education regarding proper positioning and transporting of residents.

Resident #001 was transported in their mobility device in a reclined position without support to an identified body part causing an injury to the resident's identified body part. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to Log #028399-18:

A critical incident report (CIR) was submitted to the Director on identified date, for an incident of an alleged staff to resident abuse involving resident #014. The CIR indicated on an identified date, staff #181 found resident #014 sitting in an identified room adjacent to the dining room, the door to the room was noted to be locked. The resident was calling for help. Upon inquiry, PSW #182 indicated to staff #181 that the resident was exhibiting responsive behaviours and that the resident was to sit in the identified room in the evening. Staff #181 stayed with resident #014 until the resident finished their meal.

Review of the licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01- 03-05, reviewed November 2017, November 2018), indicated under:
Internal Reporting and Investigation Requirements (page 12/18):
-staff members who witness or suspect or who have been notified of alleged abuse will immediately report to a supervisor or manager.

A review of CIR, indicated the CIR was submitted on identified date and time, one day after the incident had occurred. The CIR review indicated that MOHLTC after hours pager was not contacted about this incident.

During an interview with resident care coordinator (RCC) #176, they indicated to Inspector #570, the incident was reported and investigated on identified date, as soon as the incident was reported by staff #181. The RCC indicated that staff #181 did not immediately report the incident to their supervisor as required by the abuse and neglect-prevention policy.

During an interview with the DOC, they confirmed to Inspector #570, that the incident should have been immediately reported using the after hours number.

The licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating was not complied with, when staff #181 did not immediately report the incident to their supervisor. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Under O. Reg. 79/10, s. 104 (3), when making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log #028399-18:

A critical incident report (CIR) was submitted to the Director on identified date and time, for an incident of an alleged staff to resident abuse involving resident #014. The CIR indicated on identified date, staff #181 found resident #014 sitting in an identified room adjacent to the dining room, the door to the room was noted to be locked. The resident was calling for help. Upon inquiry, PSW #182 indicated to staff #181 that the resident was exhibiting responsive behaviours and that the resident was to sit in the identified room in the evening. Staff #181 stayed with resident #014 until the resident finished their meal.

During an interview with Staff #181, they indicated to Inspector #570, that resident #014 was sitting in the identified room and both doors were closed. Staff #181 indicated that, around an identified meal time, the resident was calling out and pointing to people. The resident seemed unhappy.

During an interview with resident care coordinator (RCC) #176, they indicated to Inspector #570, the incident was investigated on an identified date, as soon as the incident was reported by staff #181.

During an interview with the Director of Care (DOC), they indicated to Inspector #570, staff should have not closed the doors and that behaviour support staff should have been called to assist. The DOC indicated that CIR should have been amended with the outcome of the investigation.

The licensee did not report to the Director the results of the investigation of the alleged staff to resident emotional abuse. [s. 23. (2)]

Issued on this 19th day of September, 2019

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

Original report signed by the inspector.