Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Jan 24, 2020	2020_626501_0001	019469-19, 019548-19, 019549-19, 019550-19, 020285-19, 020748-19, 022033-19, 022035-19, 022826-19	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

SUSAN SEMEREDY (501), ASAL FOULADGAR (751), JACK SHI (760)

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): January 7, 8, 9, 10, 13, 14, 15, 16, 17, 20 and 21, 2020.

This inspection occurred concurrently with complaint inspection #2020_626501_0002.

The following intakes were inspected:
Two intakes related to falls prevention
Three intakes related to the prevention of abuse and neglect
One intake related to safe and secure home
Three intakes related to follow ups for a compliance orders

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinators (RCC), occupational therapist (OT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and substitute decision-makers (SDM).

During the course of inspection, the inspectors(s) conducted observations of staff and resident interactions and the provision of care, reviewed health records, home's investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 52. (2)	CO #003	2019_715672_0005	501
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2019_715672_0005	501
O.Reg 79/10 s. 8. (1)	CO #002	2019_715672_0005	501

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1.The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care

(MLTC) related to resident #002 who eloped from the home. The resident was returned the next day having sustained minor injuries.

A record review of resident #002's progress notes indicated that prior to their elopement, the resident was demonstrating responsive behaviours which included signs they were preparing to leave the home.

Record reviews further indicated that a PSW informed a registered staff that they could not find resident #002. A search of the building was conducted including all rooms and units and the registered nurse (RN) who was the emergency coordinator of the home was notified as well. A phone call was received shortly after indicating the resident was found away from the home and would be returned the next day. Staff reviewed surveillance video the following day which indicated resident #002 left the home by punching the code to exit the building.

An observation conducted during the course of the inspection by Inspector #760 indicated that the home was publicly posting the door code by the exit doors.

A record review of resident #002's written plan of care did not yield any interventions related their risk of elopement from the home, at the time of this incident.

A review of the home's investigation notes related to the incident indicated that the staff members on resident #002's home unit did not complete a census report at the end of their shift. During the home's investigation interviews, all the staff members indicated that a census report was to be filled out on the first and last 30 minutes of each shift to account for all the residents on their unit.

An interview with RPN #113 indicated resident #002 could have been injured during their elopement. RPN #113 confirmed that resident #002 came back the next day and sustained a minor injury. An interview with RPN #124 stated during after-hours, residents who are cognitively intact can punch in the code for the front door, which is publicly posted and leave the building without any staff knowing, as there are no staff actively monitoring the front doors during after-hours.

Interviews with RCC #104 and DOC #122 confirmed resident #002 eloped from the home by punching in the front door code which was and still is publicly posted. RCC #104 indicated that evening staff should have completed a census report at the end of their shift and confirmed the home failed to ensure it was a safe and secure environment

for resident #002.[s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment and devices for the falls prevention and management program were readily available at the home.

A CIS report was submitted related to resident #001's fall which resulted in a significant change.

A record review indicated resident #001 had a prior fall and a referral was completed on the same day by RPN #101 to the occupational therapist (OT). The referral requested the application of an identified fall prevention device since the previous fall prevention device was ineffective. OT #103 followed up with the referral the next day and indicated that staff were to continue using the previous fall prevention device with suggested modifications and indicated the requested fall prevention device would be provided as soon as it became available.

An interview with RN #102 indicated that the home's process for getting a fall prevention device would involve a referral to the OT. An interview with RPN #101 indicated a referral to the OT was made following resident #001's prior fall, but that the fall prevention device was not available in the home at that time.

An interview with OT #103 indicated that either themselves or an assistant would provide the fall prevention device for a resident following a referral made to them by the registered staff. OT #103 also stated a referral was received following resident #001's prior fall, and staff had requested the new fall prevention device which was not available.

An interview with RCC #104 indicated they preferred the use of the fall prevention device that was requested by staff after resident #001's prior fall and confirmed that it would have been a more beneficial fall prevention intervention for resident #001. RCC #104 verified that the modification suggested by OT #103 was not an effective approach for resident #001. RCC #104 further indicated that nursing staff should have continued to try to look for the suggested fall prevention device by speaking with the management who could have attempted to provide one from alternative sources.

The home failed to ensure equipment and devices used for the falls prevention and management program were readily available at the home. [s. 49. (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 devices for the falls prevention and management program are readily available at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff who provide direct care to the resident.

The licensee received compliance order #001 from inspection #2019_715672_0005 related to staff failing to collaborate with each other in the assessments of residents including resident #011 after sustaining a fall. Resident #011 was selected to complete the follow up inspection.

A review of resident #011's current written plan of care indicated the resident was at risk for falls and as an intervention was to use identified falls prevention and management devices.

An observation indicated resident #011 did not have these devices.

An interview with PSW #106 indicated resident #011 was no longer in need of such devices since after their last fall there had been a significant change in their mobility.

An interview with RCC #108 confirmed that resident #011's written plan of care did not provide clear directions to staff as it indicated the resident required devices which were no longer necessary. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff who provide direct care to resident #003 were kept aware of the contents in their plan of care.

A CIS report was submitted related to an incident of abuse between resident #003 and #004. According to the report, one-to-one monitoring was started for resident #003 shortly after this incident.

A review of resident #003's current written plan of care indicated distance between resident #003 and #004 should be maintained.

Interviews took place with PSW #132 who was covering for resident #003's one-to-one on break and PSW #133 who was a one-to-one for resident #003. PSW #132 and #133 did not correctly identify resident #004 as the resident who resident #003 was not to be in close proximity with. Both thought resident #003 was not be in close proximity with another co-resident.

An interview with RCC #108 verified that it was part of resident #003's written plan of care that resident #003 and #004 should maintain a distance from one another. RCC #108 confirmed the home failed to ensure that the one-to-one PSW's working with resident #003 were kept aware of the contents in their plan of care.
[s. 6. (8)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #004 from abuse.

A CIS report was submitted related to an incident of abuse between resident #003 and #004. According to the report, one-to-one monitoring was started for resident #003 shortly after this incident.

A record review of resident #003's written plan of care at the time of the incident, indicated resident #003 had a history of identified responsive behaviours.

A record review of progress notes for resident #003 indicated an identified person told RPN #129 that resident #003 asked resident #004 if they could touch them in an identified body area. It was indicated resident #004 did not provide a response and that resident #003 proceeded to touch resident #004. RPN #129 responded and when arrived, resident #003 was not exhibiting any responsive behaviours. Resident #004 was assessed and did not appear to have any changes in their status.

An interview with RN #131 who was on duty and informed about the incident, confirmed resident #003 touched an identified body area of resident #004 and following this incident, resident #003 was placed on one-to-one monitoring.

A record review of the CIS report indicated that resident #004 was noted to have a cognitive impairment and an identified Cognitive Performance Scale (CPS) score. In an interview with RCC #108, they indicated that the home determines when a resident has an identified CPS score or above, they would not be able to provide consent as they would not have an understanding or appreciation of the consequences of their actions.

An interview with RCC #108 confirmed the home did not protect resident #004 from abuse by resident #003.

These findings are further evidence to support the order issued on December 23, 2019, during critical incident system inspection #2019_643111_0021 to be complied February 28, 2020. [s. 19. (1)]

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.