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 14, 2022	2021_875501_0025	014942-21, 015294-21, 015459-21, 017206-21, 018522-21	Complaint

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), JULIE DUNN (706026), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 14, 15, 16, 17, 20, 21, 22, 23, 2021.

The following intakes were completed in this complaint inspection:
Log #014942-21 related to Infection Prevention and Control (IPAC) practices, dining, and recreational services
Log #015294-21 related to the prevention of abuse and responsive behaviours
Log #015459-21 related to IPAC practices and safe and secure home
Log #018522-21 and #017206-21 related to falls prevention and pain management

NOTE: A Written Notification and Voluntary Plan of Correction (VPC) related to LTCHA s.19(1) and O.Reg. 79/10 s. 8(1)(b) were identified in a concurrent inspection # 2021_875501_0026 and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinators (RCCs), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist, Infection Control Practitioner, Manager of Food Services, Coordinator of Recreation and Therapy, Housekeeping Aides, Dietary Aides, Laundry Aides, Recreation Aides, Receptionist (COVID-19 testing), Surveillance Supervisor, family members, substitute decision-makers (SDMs) and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, dining and recreation services and IPAC practices. The inspectors reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Falls Prevention
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **5 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the policy and procedures for monitoring of food temperatures was complied with.

Under Regulation 79/10, s. 73(1) 6, food and fluids are to be served at a temperature that is both safe and palatable to the residents.

Under Regulation 79/10, s.68(2)(a), the nutrition care and hydration programs are to include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition and dietary services and hydration.

During lunch service a Dietary Aide (DA) was observed taking the temperatures of all food prior to serving. The DA was observed not recording the food temperatures on the food temperature logs until after the meal service was completed and was recording all hot food temperatures as 80 degrees Celsius (and cold food temperatures as 4 degrees Celsius), regardless of the actual temperatures obtained. The DA confirmed that this was their common practice. Two hot food items were identified as below 140 degrees Fahrenheit and no actions were taken.

The home’s policy indicated that all food temperatures were to be obtained and recorded prior to the meals provided, based on the digital thermometer readings and hot food was to be maintained between 140 to 165 degrees Fahrenheit or hotter with appropriate actions taken if they did not fall within those parameters. The Manager of Food Services confirmed the dietary staff were expected to follow the home’s policy for obtaining and recording of food temperatures, and taking appropriate actions as required.

Sources: Observations, policy Food Temperature Control (FOOD-04001-40) reviewed November 10, 2020, Food temperature sheets, meal tracker for a resident, and interviews with the Manager of Food Services and other staff.

2. The licensee has failed to ensure that their policy for drug destruction was complied with.

Under O.Reg. 79/10, s. 114 (3) (a), the home is to have written policies developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for medication management, which includes drug destruction.

The home's policy for drug destruction stated medications were to be denatured and/or destroyed by a member of the registered staff and the pharmacist, physician or 2 registered staff. There were two medication incidents that were discovered when an RPN had disposed of a number of medications that included narcotics, for two residents into a sharps container, despite signing for the medications as administered. The DOC confirmed that the RPN did not follow their process for drug destruction.

Sources: Critical Incident Reports, review of the electronic Medication Administration Records (eMar) and narcotic sheets for two residents and an interview with the DOC. [s. 8. (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 where the Act or O.Reg. 79/10 requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: 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 has failed to ensure resident #002 and #010 were protected from abuse.

A resident had a history of inappropriate comments and behaviours towards residents and staff and an intervention had been reduced. This resident made an inappropriate comment directed towards resident #002. When resident #002 reported this to an RN they appeared noticeably upset.

Another resident who also had similar responsive behaviours entered resident #010's room and began touching them inappropriately. Staff were unable to intervene to protect resident #010. An interview with an RCC confirmed resident #010 was not protected from abuse.

Failing to protect residents from abuse causes emotional distress to residents.

Sources: Critical Incident Report, resident clinical records including progress notes and interviews with RCC, an RN and other staff members. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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 ensure that the person who had reasonable grounds to suspect abuse immediately reported the suspicion and the information upon which it is based to the Director.

A resident had a history of inappropriate comments and behaviours towards residents and staff. A co-resident reported to an RN that this resident made an inappropriate comment directed towards them. According to an RN, the resident who reported the incident was visibly upset and according to a PSW remembered the incident several days later.

Failing to report incidents of abuse puts residents at risk for further incidents of abuse.

Sources: Residents' clinical record including progress notes and interviews with an RN and other staff members. [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 the person who has reasonable grounds to suspect abuse of resident immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken to meet the needs of a resident's responsive behaviours included reassessments, interventions and documentation of the resident's responses to the interventions.

The home was unable to protect two residents from a resident who had a history of inappropriate responsive behaviours. The home implemented interventions at different times however behaviours continued. A review of the resident's record indicated there was a lack of reassessment that demonstrated how the resident was responding to each of the interventions.

An interview with an RCC confirmed this resident's responsive behaviours lacked reassessment to indicate why interventions were discontinued and or modified.

Failing to reassess residents with responsive behaviours and document their responses to interventions puts staff and residents at actual risk for harm.

Sources: Residents' clinical record including progress notes and interviews with an RCC and other staff. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours, actions are taken to meet the needs of the resident including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that the recreation and social activities program included the development and implementation of a schedule of recreation and social activities that were offered during days, evenings and weekends, and communication of the schedule to all residents and families.

Observation of the activity white board indicated there was only one activity scheduled for that day. There was also no monthly activity calendar posted anywhere on the unit. An RN indicated the unit frequently had no activities occurring due to staffing shortages in programming. A Recreation Aid confirmed they did not post the monthly calendars and only posted the activities that were occurring that day on the white board, as they frequently had to cancel programs, due to staffing issues or being reassigned to other duties. Review of the monthly calendar for December 2021 indicated there was no activities offered during the evenings or on Mondays. There was also no activities offered on the weekend of December 11 to 12, 2021. The Coordinator of Recreation and Therapy also confirmed they had to be flexible with programming due to the pandemic and currently having six vacant recreation positions.

Failing to provide residents with recreation and social activities during the evenings and weekends, and that which is communicated to all residents and families, can lead to reduced quality of life.

Sources: Observations, review of activity board, activity calendar, recreation staffing schedules and interview with the Coordinator of Recreation and Therapy and other staff. [s. 65. (2) (b)]

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 recreation and social activities program for the home includes the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends, to be implemented voluntarily.

WN #6: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1.The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

A resident fell and sustained a fractured hip. The resident's care plan and transfer logo displayed above the resident's bed indicated the resident required certain assistance for transfers. A PSW stated the resident required less assistance for transfers. The Physiotherapist confirmed the resident's transfer needs were different from what was indicated in the resident's care plan and the logo displayed above the resident's bed, and stated they would arrange for reassessment of the resident's transfer needs.

Sources: Critical Incident Report, a resident's care plan and transfer logo, and interviews with the Physiotherapist and other staff. [s. 6. (10) (b)]

Issued on this 18th day of January, 2022

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

Original report signed by the inspector.