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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 29, 2022	2022_598570_0004	002904-21, 006331-21, 019723-21, 001386-22	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)

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 14 -18, 2022

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Log #002904-21, CIS report, related to an allegation of neglect of a resident.
- Log #006331-21, CIS report, related to an allegation of abuse of a resident.
- Log #019723-21, CIS report, related to a fall incident.
- Log #001386-22, CIS report, related to a fall incident.

During the course of the inspection, the inspector(s) spoke with Assistant Administrator, Manager Quality, Risk & Community Support for the Division, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Occupational Therapists (OT), Infection Control Practitioner, Housekeeping Aides, Screening and Surveillance Supervisor, Screeners, and residents.

During the course of the inspection, the inspector observed resident and staff interactions and IPAC practices. The inspector reviewed clinical health records, relevant home policies, investigation notes, audit records and other pertinent documents.

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

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist resident #003 with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #003 was observed with their assistive device in use.

A review of the resident's plan of care did not identify the use of the the specified device as a PASD.

In an interview with PSW #107, they indicated the specified device was used for resident #003 for repositioning.

In interviews with Physiotherapist (PT) #110 and Occupational Therapists (OT) #112 and #113, they indicated the use of the specified device is considered as a PASD.

In interviews with RN #108 and OT #113, they confirmed that the use of a specified device by resident #003 was not included in the resident’s plan of care.

Sources: Resident #003's clinical records; observations; interviews with PSW #107, PT #110, OT #112 and #113, and RN #108. [s. 33. (3)]

2. The licensee has failed to ensure that a PASD was used to assist resident #006 with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #006 was observed with their assistive device in use.

A review of the resident's plan of care did not identify the use of the assistive device as a PASD.

In interviews with PSWs #107 and #114, they indicated the assistive device was used for resident #006 for positioning.

In interviews with RN #108 and OT #113, they confirmed that the assistive device by resident #006 was not included in the resident’s plan of care.

Sources: Resident #006's clinical records; observations; interviews with PSW #107, #114, OT #113, and RN #108. [s. 33. (3)]

3. The licensee has failed to ensure that a PASD was used to assist resident #007 with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #007 was observed with their assistive device in use.

A review of the resident's plan of care did not identify the use of the device as a PASD.

In an interview with PSW #107, they indicated the assistive device was used for resident #007 for comfort.

In interviews with RN #108 and OT #113, they confirmed that the use of the device by resident #007 was not included in the resident's plan of care.

Failing to ensure that residents #003's, #006's and #007's interventions related to assistive devices were included in their plan of care, put residents at risk of harm related to incorrect use of assistive devices.

Sources: Resident #007's clinical records; observations; interviews with PSW #107, OT #113, and RN #107. [s. 33. (3)]

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 a PASD is only used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #2: 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 a person who had reasonable grounds to suspect neglect of a resident immediately reported the suspicion and the information upon which it is based to the Director.

A Critical Incident System (CIS) report related to an allegation of neglect, was submitted to the Director five days after the incident had occurred

,
During an interview, Resident Care Coordinator (RCC) #103 acknowledged that the allegation of neglect was not immediately reported to the Director.

Failing to report incidents of neglect puts residents at increased risk of harm.

Sources: CIS report and interview with RCC #103. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day of resident #003's fall which caused an injury to the resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #003 had sustained a fall for which they were taken to hospital and diagnosed with injury. A report to the Director was not made until six days after the confirmed diagnosis of the injury.

During an interview, Resident Care Coordinator (RCC) #103 acknowledged the home became aware of the resident's diagnosis of injury on the same date the resident was sent hospital.

Sources: Interview with RCC #103, and Critical Incident Report. [s. 107. (3) 4.]

Issued on this 1st day of April, 2022

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

Original report signed by the inspector.