Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 25, 2024
Original Report Issue Date: December 20, 2023
Inspection Number: 2023-1559-0003 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates, Oshawa

Amended By Julie Dunn (706026)	**Inspector who Amended Digital Signature** Julie Dunn Digitally signed by Julie Dunn Date: 2024.01.25 15:56:00 -05'00'

AMENDED INSPECTION SUMMARY

This amendment has been completed at the request of the long-term care home for compliance order (CO) #001 and CO #002, to allow time to complete required activities as indicated in the orders. The compliance due date (CDD) for both orders will be amended to April 18, 2024.

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Lead Inspector Julie Dunn (706026)	**Additional Inspector(s)** Rexel Cacayurin (741749) Rita Lajoie (741754)
Amended By Julie Dunn (706026)	**Inspector who Amended Digital Signature** Julie Dunn Digitally signed by Julie Dunn Date: 2024.01.25 15:56:26 -05'00'

AMENDED INSPECTION SUMMARY

This amendment has been completed at the request of the long-term care home for compliance order (CO) #001 and CO #002, to allow time to complete required activities as indicated in the orders. The compliance due date (CDD) for both orders will be amended to April 18, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27 – 30 and December 1 and 4 - 6, 2023.

The following intake(s) were inspected:

- Intake: #00093750 - Follow-up to inspection 2023-1559-0002, Compliance Order (CO) #001 FLTCA, 2021 s. 24 (1) with Compliance Due Date (CDD) of September 25, 2023.
- Intake: #00093749 - Follow-up to inspection 2023-1559-0002, CO #002 O. Reg. 246/22 s. 53 (1) 4. with CDD of September 25, 2023.
- Intake #00099094 related to a complaint regarding concerns with abuse, communication, medication administration.
- Intake #00090613 related to a complaint alleging improper care and neglect of a resident.
- Intake #00099784 related to a complaint regarding concerns about misuse of funding, staffing plan.
- Intakes #00020395, #00097651, #00097764, #00093649, #00099184 related to allegations of staff to resident abuse/neglect.
- Intake #00087745 related to an allegation of improper/incompetent treatment of a resident.
- Intake #00096201 related to a resident-to-resident altercation.
- Intake: #00096261 related to medication management.

The following intake(s) were completed in this inspection:

- Intakes #00096268 and #00094659 related to medication management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1559-0002 related to O. Reg. 246/22, s. 53 (1) 4. inspected by Rita Lajoie (741754)

Order #001 from Inspection #2023-1559-0002 related to FLTCA, 2021, s. 24 (1) inspected by Rexel Cacayurin (741749)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Pain Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
The licensee failed to ensure a resident's right to freedom from abuse.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director reporting an altercation between two residents that caused an injury.

A progress note from a registered nurse (RN) indicated that two residents were yelling at each other in the hallway close to the nursing station. An altercation occurred resulting in injury to one of the residents. The injured resident was assessed and was sent to the hospital.

The Behaviour Support Ontario (BSO) manager acknowledged the incident as an abuse to a resident by co-resident.

The long-term care (LTC) home's policy defined physical abuse as the use of physical force by a resident that causes physical injury to another resident regardless of cognitive capacity.

Failing to ensure the resident's right to freedom from abuse resulted in injury to the resident.

Sources: Clinical records, LTC home's policy, interview with staff. [741749]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
The licensee failed to ensure that it was immediately reported to the Director when a person had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident occurred.

Rationale and Summary
A CI report was received by the Director for a complaint from a resident's substitute decision maker (SDM) alleging improper or incompetent care.

On a particular date, a Personal Support Worker (PSW) entered a resident's room when the resident was receiving care from a third-party care provider. The resident stated they were in pain and requested that the care be stopped. The PSW asked the care provider to stop as the resident was in pain and requesting not to continue with treatment. The PSW then left the room, indicating they assumed that the care provider had stopped providing care.

The PSW indicated that they reported the incident to registered staff, including their observations of the actions of the third-party care provider, their conversation with them and the resident's response to care. The PSW indicated they could not remember the name of the registered staff they had reported the incident to.

The Resident Care Coordinator (RCC) indicated that they received a letter from the resident's SDM three days later, requesting follow-up to the incident with the third-

party care provider. The RCC indicated this was the first they had been made aware of the incident and submitted a CI report.

The RCC indicated that they interviewed the PSW regarding the incident. The RCC indicated that they did not believe that the PSW interpreted the incident as improper care or abuse and that the PSW did not report the incident to registered staff.

A review of the resident's clinical records demonstrated that there was no documentation by registered staff about the incident and no relevant assessments completed on the resident following the incident.

Failure to ensure that the improper care was immediately reported put the resident at ongoing risk of experiencing pain during the provision of care.

Sources: Interviews with staff, clinical records, complaint letter from SDM, LTC home's internal investigation notes.
[741754]

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.

1. The licensee failed to ensure that the response provided to the substitute decision maker (SDM) for a resident when they made a complaint included,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary
A CI report was submitted to the Director regarding a complaint received from a substitute decision maker (SDM) alleging staff to resident emotional abuse.

The RCC confirmed that it is an expectation that there would be a written response from the home to a complainant when a complaint has been submitted. The RCC indicated that the Director of Care (DOC) had the written letter of response to a complaint made by the SDM of the resident. The RCC indicated that when they asked the DOC about the letter they told them that a verbal response was given to the resident with the intent that they share it with their SDM.

The DOC verified that the home's internal investigation was complete and that there was no written letter of response sent to the complainant providing the outcome of the investigation, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman and an explanation of what the licensee has done to resolve the complaint.

The home's internal investigation notes file did not contain a response letter to the SDM's complaint. There was no written or verbal response to the complainant acknowledging receipt of the complaint to indicate that it was being investigated. There was no written response providing the outcome of the

investigation or detailing follow up contact information for complaint submission to the ministry.

Failure to provide a written response with the required follow up and contact information may put the resident at risk for disinclination to bring forward complaints regarding care.

Sources: Interviews with staff and the resident, written complaint submitted by resident's SDM, LTC home's internal investigation file.
[741754]

2. The licensee failed to ensure that a response was provided to the SDM for a resident when they made a complaint including,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary
A CI report was submitted to the Director regarding a complaint received from a resident's SDM alleging incompetent care of the resident.

The RCC indicated that they did not provide a written response to the complainant.

The DOC verified that the LTC home's internal investigation into the complaint was complete and that there was no written letter of response sent to the complainant providing the outcome of the investigation, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman and an explanation of what the licensee has done to resolve the complaint.

The home's internal investigation notes file did not contain a response letter to the complainant. There was no written or verbal response to the complainant acknowledging receipt of the complaint to indicate that it was being investigated. There was no written response providing the outcome of the investigation or detailing follow up contact information for complaint submission to the ministry.

Failure to provide a written response with the required follow up and contact information may put the resident at risk for disinclination to bring forward complaints regarding care.

Sources: Interviews with staff, clinical records, LTC home's internal investigation file. [741754]

3. The licensee failed to ensure that a response was provided to the family of a resident when they made a complaint including,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the

reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Summary and Rationale:
A CI report was submitted to the Director indicating the family of a resident alleged abuse of the resident and inadequate communication from the LTC home.

Two written complaints were submitted to the LTC home on two different dates by the family of the resident. The LTC home's internal investigation documents did not include any response to the family of the resident.

The DOC indicated that they were unable to find any formal written response to the two written complaints that were received from the family of the resident, which led them to believe that written responses had not been completed and provided to the complainant.

In failing to provide a written response with the required follow up and contact information, there is increased risk of hesitation to bring forward concerns regarding suspected resident abuse and neglect and other care concerns.

Sources: Interview with DOC, LTC home's internal investigation documents. [706026]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.

The licensee failed to ensure implementation of their drug destruction and disposal policy related to: a controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, until the destruction and disposal occurs.

In accordance with Ontario Regulations (O. Reg.) 246/22, s. 11. (1) (b), the licensee is required to ensure that the High Alert Medication: Transdermal Patch System specifically section 3.3 (K) of the policy, is complied with as a part of the Medication Management System in the home.

Rationale and Summary
A CI report was submitted to the Director related to a missing controlled drug. A transdermal patch was missing while completing the home's routine drug destruction audit by the pharmacist and the medication management lead.

The LTC home's internal investigation note from an RPN indicated that they disposed the old transdermal patch from a resident incorrectly and discarded it in a garbage bin instead of the secure discarded medication receptacle.

The medication management lead acknowledged that the RPN failed to follow the home's policy in discarding or disposing of the transdermal patch properly. They also indicated that the RPN was involved in a similar incident with another resident. The resident received the transdermal patch as ordered.

The home's policy indicated that two nurses will sign on the transdermal patch Narcotic Medication Record for the patch that has been removed and will dispose of the expired or used transdermal patch in the secure discarded medication receptacle for controlled and monitored medications (double locked).

When the RPN did not follow the home's policy for disposal and discarding of controlled substances, there was increased risk of controlled substance diversion with the incorrect disposal.

Sources: LTC home's internal investigation, interview with staff, LTC home's policy. [741749]

(A1)

The following non-compliance(s) has been amended: NC #005

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Develop and implement:

A) Reporting and Communication Protocol for contacting the physician or nurse practitioner related to residents who

i) have health concerns upon admission that require urgent assessment,

ii) experience sudden health status change or unusual decline in their baseline health status.

B) Guidelines defining criteria for health conditions or situations that may require immediate reporting and communication.

2. The Reporting and Communication Protocol must outline the expected

turnaround time for the physician's / NP's response, the actions to be taken by the registered staff if they do not receive a response within that time and notification of all team members involved in the resident's circle of care specific to their care needs including but not limited to the skin and wound lead, falls lead, dietician, physiotherapist, BSO lead, social worker, occupational therapist.

3. Provide in-person education to the registered staff in the home about the protocol and guidelines developed for part 1.

4. Maintain records of the education provided including the educational materials, date(s) of training, staff attendance, and the name(s) of the individual(s) who provided the education. Provide these records to the Inspector immediately upon request.

5. Designate a nursing management lead to develop and implement an audit tool to monitor and document implementation of the Reporting and Communication Protocol and reporting guidelines. Conduct audits weekly on the specific resident home area for a minimum of four weeks. The audit records must include who is conducting the audit, date, time, identification of any deficiencies, the staff member responsible and the corrective action taken to ensure staff are aware of the deficiency. Retain the audits and ensure that they are immediately available to the Inspector upon request.

Grounds

The licensee has failed to ensure that staff and others collaborated in the assessment of a resident so that assessments were integrated, consistent with and complemented each other.

Rationale and Summary

A complaint was received by the Director for concerns regarding assessments, improper care and neglect of a resident.

A Registered Dietician (RD) confirmed that they completed the admission assessment for the resident and that according to their SDM, the resident had experienced certain symptoms prior to admission to the LTC home. The RD indicated that the SDM had shared the information with the nursing staff as well. The RD confirmed that the symptoms would be nursing issues that they should look into. The RD confirmed that collaboration is required when a resident has complex needs. The RD confirmed that they could make a referral for the physician or NP to see a resident if they were concerned about them but that was usually within nursing's scope.

The Nurse Practitioner (NP) confirmed that an admission assessment is to be completed by the physician within seven days of a resident's admission to the LTC home. The NP confirmed that when an initial nursing assessment is completed on admission and the nurse has concerns about a newly admitted resident that they would typically reach out to the NP. The NP confirmed that the fact that the resident was experiencing certain symptoms upon admission would warrant an earlier admission assessment by medical staff, but no one reached out to them about seeing the resident. The NP indicated that it depends on the staff and whether or not they would make the decision to request NP assessment. Nursing staff can contact them if they have immediate concerns. The NP indicated that they depend on the nursing staff to update them about whether or not an intervention they ordered is working.

An RN indicated that the resident was in the LTC home for a short time and they were already very ill when they were admitted to the home. Deterioration had been going on for a period of time. The RN indicated that they assessed the resident as

being at their admission baseline and did not feel that they needed to be transferred to the hospital.

The RPN reported to the RN that they had done an assessment, that the resident needed to go to hospital. The RN did not agree and they contacted the resident's SDM an hour or two later. The SDM indicated they were okay with continuing to monitor the resident based on the RN's clinical judgement. When visiting the resident on a later date, the SDM observed significant deterioration and asked that they be sent to hospital.

A few weeks later, the resident's SDM submitted a complaint to the Infoline with concerns about the care the resident received. The resident was experiencing certain symptoms for a period of time prior to admission and at time of admission. The resident's symptoms continued while in the home despite attempts to treat the symptoms. Of primary concern to the SDM in their complaint was the confusion generated after conflicting assessments and reports by registered staff.

The Doctor's notification / communication book included entries by nursing staff notifying the physician of concerns regarding the resident. There was no indication from notations in the book or in the clinical records that a physician assessed the resident during this time.

Clinical records indicated that the resident had experienced certain symptoms for two months, had not been eating for the last month and had significant weight loss.

The LTC home's policy indicated that 'nursing staff works collaboratively with team members to communicate changes in (resident) status.' 'The physician, RCC, RD, and NP (if applicable), are notified of changes in (resident) status as they occur. Nursing staff maintain contact with the family/POA/SDM, as applicable, as well as

document/monitor and evaluate current interventions and send referral as applicable for reassessment.'

Failure to ensure integrated assessments of the resident so that they were consistent with and complemented each other put the resident's health at significant risk.

Sources: Interviews with staff, complaint record, clinical records, LTC home's Policy. [741754]

This order must be complied with by April 18, 2024.

(A1)

The following non-compliance(s) has been amended: NC #006

COMPLIANCE ORDER CO #002 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1. Provide all direct care staff with in-person education on the prevention of abuse and neglect of residents.

2. The training will include the definitions and scenarios of types of abuse and neglect, including emotional abuse, the duty of staff to protect residents from all

types of abuse and neglect, and the staff roles and responsibilities for any alleged, suspected or witnessed incidents of resident abuse or neglect.

3. The training will include a method for the staff to demonstrate their understanding of the training provided. A documented record will be kept of this demonstration.

4. Maintain a record of the training completed, including but not limited to, dates of training, names of staff who provided the training and who attended the training, and the content of the training. Retain the training records, and the records are to be made immediately available to Inspectors upon request.

Grounds

1. The licensee failed to ensure that a resident was protected from abuse by staff.

Section 2. (1) of the Ontario Regulation 246/22 defines emotional abuse as, "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Rationale and Summary:

A CI report was submitted to the Director indicating there was an allegation of staff to resident abuse.

The care plan for a resident indicated the resident required extensive assistance from two staff for some activities of daily living and included specific instructions for staff when assisting the resident.

A staff member indicated that a PSW was abrupt and too fast in providing care for

the resident. The LTC home's internal investigation documents indicated that the PSW was fast and abrupt when providing care and when speaking with the resident and poured water on the resident. The LTC home's internal investigation summary indicated that the allegation of abuse was found to be substantiated.

The RCC indicated that the home became aware of the allegation of emotional abuse of the resident by the PSW and the allegation of abuse was substantiated.

Failure to ensure that the resident was protected from abuse by the PSW resulted in risk of emotional harm to the resident.

Sources: Interviews with staff, LTC home internal investigation documents, clinical records. [706026]

2. The licensee has failed to ensure that a resident was protected from abuse by a PSW.

Section 2. (1) of the Ontario Regulation 246/22 defines emotional abuse as, "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Rationale and Summary
A CI report was submitted to the Director in response to a complaint made to the licensee alleging emotional abuse of a resident.

In an interview, the RCC confirmed that there were three different interactions between the resident and the PSW that constituted neglect. They indicated that in

this situation, neglect was substantiated through the LTC home's internal investigation.

The resident confirmed in an interview that the PSW would come in, turn the call bell off and leave without asking them what assistance they needed or stand with their back to the door after entering the room and not provide assistance. The resident also told their family that they were afraid of retaliation by the staff if they asked for care. The resident confirmed that the interactions with the PSW had left them feeling "sub-human".

In a complaint submitted by the resident's SDM to the RCC, they indicated that a specific request had been made to the RCC regarding the resident's care. After this request had been made and the care instruction was added to the task list in Point of Care (POC), the care that the resident was provided changed. The resident reported to their family that several times in the same week their call bell had been turned off and the care requested had not been completed.

Review of the LTC home's internal investigation notes for the incidents indicated that the allegation of emotional abuse had been substantiated.

Failure to protect the resident from emotional abuse by staff potentially compromised their physical care and contributed to fear of retaliation.

Sources: Interviews with staff and resident, complaint record, LTC home's internal investigation notes.
[741754]

This order must be complied with by April 18, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.