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
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Oshawa, ON, L1H 1A1
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Public Report

Report Issue Date: December 11, 2024

Inspection Number: 2024-1559-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Regional Municipality of Durham

Long Term Care Home and City: Hillsdale Estates, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 - 22, 25, 26, 28, 29, and December 2, 3, 2024.

The following intake(s) were inspected:
- Intake: #00107070 and intake: #00112995 related to physical/verbal abuse of residents by staff.
- Intake: #00107981 related to medication incident/adverse drug reaction.
- Intake: #00108982 and intake: #00112707 related to emotional abuse of residents by staff.
- Intake: #00109456 related to missing resident's belongings.
- Intake: #00116399 related to missing/unaccounted for controlled substance.
- Intake: #00118182 related to a complaint regarding the bill of rights.
- Intake: #00125207 and intake: #00130161 related to outbreaks.
- Intake: #00125780 related to a complaint regarding medication administration.
- Intake: #00114049 related to a fall resulting in an injury.

The following intakes were completed in this inspection: Intake: #00115297 and Intake: #00116014 were related to falls.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

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) 19. i.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of their plan of care,

The licensee failed to ensure that a resident participated fully in the development, implementation, review and revision of their plan of care.

Rationale and Summary
The resident was diagnosed with a new condition that required a specific treatment.

The treatment was to be initiated at another facility and administered to the resident over a specified time at the Long-Term Care Home (LTCH). A plan of care was developed by the LTCH prior to the start of the treatment.

The resident did not agree with the plan of care. They believed they did not get to fully participate in the development of their plan of care. They reported the plan of care was written by the LTCH and given to them with the expectation that it was to be followed. The resident stated they did not understand the reason for some aspects of the plan of care. Further, their physician at the treatment facility did not recommend these aspects of the plan of care.

The Director of Care (DOC) reported that the plan of care was developed in collaboration with all departments at the LTCH as well as external resources and the plan was presented to the resident. The DOC stated that the resident could provide feedback but could not direct the plan of care. In a letter to the resident the DOC stated the resident must comply with the plan as it currently was, otherwise discharge from the LTCH would be considered.

The resident experienced significant emotional distress and did not feel treated with respect when they were unable to participate fully in the development, implementation, review and revision of their plan of care.

Sources: The resident's progress notes, plan of care, LTCH's documents related this complaint, interviews with the resident, DOC and others.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that a Registered Practical Nurse (RPN) and a Registered Nurse (RN) complied with the home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
Two residents reported to the RPN alleged abuse by a Personal Support Worker (PSW). The RN was informed and directed the RPN to send an email about the alleged abuse to management. A Resident Care Coordinator (RCC) initiated the investigation and submitted the Critical Incident Report (CIR) three days later. The RCC acknowledged the staff should have reported the alleged abuse incident immediately to the Director.

The PSW continued to work in the Long-Term Care Home (LTCH) after the allegation of abuse was made placing the residents at risk of further incidents.

Sources: The residents' progress notes, CIR, LTCH's investigation notes, policy Abuse and Neglect – Prevention, Reporting, and Investigation, ADM-01-03-05, last revised December 2023, interview with RCC #109.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A Critical incident report (CIR) submitted by the home to the Director documented that the resident sustained a head injury during a transfer.

The CIR indicates the resident was agitated and tried to get up before they could transfer them.

Additionally, the home's Head Injury Routine Policy directs that Registered nursing staff will initiate a head injury routine when there is a documented head injury and are to take vital signs every 15 minutes for the first hour. The Incident report indicated that the resident's head injury routine was initiated 45 minutes after the injury.

A Registered Nurse (RN), the Falls Lead, and a Resident Care Coordinator (RCC) indicated that the expectation of the home is for a head injury routine to be initiated at the time of injury and acknowledged that it was delayed by 45 minutes.

When the transfer resulted in a head injury to the resident, failing to initiate a Head injury routine at the time of injury posed a risk to the resident.

Sources: CIR, "Head Injury Routine Policy #INTERD-03-01-01" Regional municipality of Durham, revised January 2024, the resident's clinical health records, interviews with the RN, Falls Lead/RPN, and the RCC.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (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. 246/22, s. 54 (1).

The licensee failed to comply with their fall prevention and management program when a resident had a head trauma and an unwitnessed fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention and Management Program at a minimum, provide for strategies to reduce or mitigate falls and is to be complied with. Specifically, registered staff did not comply with the policy "Post Fall Head Injury Routine Procedure", which was included in the licensee's falls prevention and management program.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director, for a fall incident involving the resident, who sustained an injury and was taken to the hospital.

A review of the resident's progress notes and fall incident reports indicated that the resident suffered a witnessed fall that resulted in head trauma and was subsequently sent to the hospital. And on the next day, the resident had an unwitnessed fall.

The home's Fall Prevention and Management policy stated that Registered Nurses (RN) or Registered Practical Nurses (RPN) would initiate a Head Injury Routine (HIR) if clinically indicated.

A review of the resident clinical health record revealed that an HIR was initiated after the first fall but not completed. No HIR was initiated following the unwitnessed fall on the next day.

An RN and the fall lead acknowledged that the initiated HIR was not completed and that no HIR was initiated after the unwitnessed fall the next day. The RN and the fall lead confirmed that the HIR following the first fall should have been completed and a new HIR should have been initiated after the second day unwitnessed fall.

Failure to initiate or complete an HIR assessment following head trauma or an unwitnessed fall may have delayed any necessary treatment if the assessment findings reveal a change in condition.

Sources: The resident's progress notes, the resident's fall incident reports, Fall Prevention and Management (Policy #: INTERD-03-08-01 Approved on February 23, 2022), the resident's clinical health record, and interview with the RN and the fall lead.

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all

drugs used in the home.

The licensee failed to comply with their written policies and protocols that were developed for the medication management system when resident #010 was administered medication.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the developed written policies and protocols for the medication management system are to ensure the accurate administration of all drugs used in the home are to be complied with. Specifically, RPN #108 did not comply with the policy "Identification of Resident", when they administered medication to resident #010 without completing two resident identifiers.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director regarding a medication incident involving resident #010. Resident #010 had been administered resident #011's medications, resulting in resident #010 being transferred to a hospital.

A review of resident #010's progress notes and Incident Report - General Incident indicated that on a specific day, all of resident #011's morning medications were administered to resident #010.

The home's Identification of Resident Policy stated that two resident identifiers are required before drug administration.

A Registered Practical Nurse (RPN) confirmed that they failed to complete two resident identifiers before administering the medication, resulting in the administration of the medication to the wrong resident.

Failing to complete two identifiers before medication administration resulted in a medication error and adverse drug reaction that put resident #010's well-being at

risk.

Sources: resident #010's progress notes, resident #010's Incident Report - General Incident, Identification of Resident Policy (Policy #: ADM-01-03-02; Approved on December 9, 2022), and interview with the RPN.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee failed to ensure that a controlled substance for a resident was stored in a double locked storage area within the home until the destruction and disposal occurs.

Rationale and Summary
A critical incident report (CIR) was submitted to the Director related to a missing controlled substance for the resident, specifically their transdermal pain patch.

The home's policy on transdermal patches directs 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 transdermal patch in the secure discarded medication receptacle for controlled and monitored medications and is double

locked.

The home's investigation notes indicate that the nurse assigned to the medication cart removed the old patch and threw it in the garbage on the med cart and applied a new one.

Medication Lead indicated the home has a policy for pain patches to discard and destroy them with two staff, and acknowledged that the staff member did not follow the policy, the staff member no longer works at the home.

Failing to ensure the controlled substance for the resident was stored in a double locked storage area until drug destruction occurred, posed a low risk that the patch could have been taken from the garbage can and used.

Sources: CIR, Policy: High Alert Medication: Transdermal Patch System (Fentanyl/Butrans) Policy #INTERD-03-03-16 Municipality of Durham, revised February 23, 2022; home's investigation notes and interviews with Medication Lead.

COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The DOC or designate to provide in-person education to an identified Registered Practical Nurse (RPN), focusing on: identification of two resident

identifiers, medication administration rights, and the home's Policies and procedures for safe medication administration. Keep a documented record of who provided the education, the date of the education provided, and the contents of the education.
2. The DOC or designate who provided the education will develop a written test containing a minimum of 10 questions covering key aspects of the training, including: identification of two resident identifiers, medication administration rights, the home's Policies and procedures for safe medication administration. A score of 90% or higher must be achieved by the RPN, with results documented.
3. The DOC or designate will conduct audits on the RPN once per week, for five residents during a scheduled medication pass to validate adherence to medication administration procedures including the proper use of two resident identifiers, medication administration rights, and the home's Policies and procedures for safe medication administration. Audits are to be completed for 3 weeks. Audit documentation must include the name of the auditor, the date and time of the audit, the residents observed, and any corrective actions taken for identified non-compliance.
4. All audits, education records, and the RPN's written test will be retained and made available to Inspectors, immediately upon request.

Grounds

The licensee has failed to ensure that no drug was administered to resident #010 unless the drug had been prescribed for the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a medication incident involving resident #010. Resident #010 had been administered resident #011's medications, resulting in resident #010 being transferred to a hospital.

A review of resident #010's progress notes and Incident Report - General Incident indicated that on a specific day, all of resident #011's morning medications were

administered to resident #010.

A review of resident #010's clinical health record revealed an allergy to a specific medication.

A review of resident #010's progress notes and resident #011's medication administration record (MAR) revealed that resident #010 was administered medications not prescribed to them, including a medication that resident #010 is allergic to, high blood pressure medications, an anticonvulsant, an antidepressant, an antineoplastic, and other medications.

A review of resident #010's progress notes indicated frequent monitoring for adverse reactions until the resident was transferred to the hospital.

The RPN confirmed that on the specific day, they administered medications to resident #010 that were not prescribed.

Failing to prevent the administration of unprescribed drugs to resident #010 posed a significant risk of adverse reactions, including an allergic response to medications, respiratory depression, and hypotension, with the potential for serious or life-threatening consequences.

Sources: resident #010's progress notes, resident #010's Incident Report - General Incident, resident #011's MAR, and interview with the RPN.

This order must be complied with by February 14, 2025

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.