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

Public Report

Report Issue Date: August 26, 2025
Inspection Number: 2025-1559-0006
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): August 18 - 22, and 25 - 26, 2025.

The following intake(s) were inspected:
- An intake regarding a resident-to-resident altercation.
- An intake regarding an allegation of verbal abuse of a resident by staff.
- An intake regarding the fall of a resident with injury.
- An intake regarding the fall of a resident with injury.
- An intake regarding a complaint.

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

Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to ensure that it was immediately reported when staff had reasonable grounds to suspect that there was verbal abuse of a resident by co-staff.

Sources: LTC home internal investigation documents, Resident's clinical records.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure staff involved in the care of a resident collaborated with each other when an assessment tool completed at the time of the resident's admission to the home was not processed.

Sources: Resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Care conference

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident’s care is held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their

substitute decision-maker, if any;

The licensee failed to ensure a care conference of the interdisciplinary team providing care for a resident was completed annually, limiting the opportunity for team members, the resident, and their substitute decision maker (SDM) to discuss and fully participate in care decisions.

Sources: Resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure that a resident, who required assistance with toileting, received assistance from staff to manage and maintain continence.

Sources: Resident's clinical records; Interviews with resident and staff.

WRITTEN NOTIFICATION: Altercations and other interactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The licensee failed to identify factors, based on an interdisciplinary assessment, documentation, staff observations of and interactions with a resident, that could potentially trigger behaviours by the resident, limiting identification and implementation of interventions.

Sources: Resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to develop and implement procedures and interventions to protect staff and a co-resident from potentially harmful responsive behaviours by a resident.

Sources: Residents' clinical records, LTC home's internal investigation file, interview with staff.

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