Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2014	2014_292553_0021	O-000556-14	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

MATTHEW STICCA (553)

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): July 7, 8, 2014

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care, Resident Care Coordinators, Infection Prevention and Control Designate, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Occupational Therapist, Physiotherapist, and Activation Staff.

During the course of the inspection, the inspector(s) Reviewed clinical health records of a resident, toured the home, observed care delivered to a resident, observed staff-resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care required for properly bathing Resident #1 was provided as specified in the plan of care.

Resident #1 experienced a fall out of a wheelchair after receiving a tub bath.

Interview with Resident #1 on July 7, 2014 at 11:20hrs

-Resident #1 stated that when Resident #1 asked for a shower, staff stated that a bath would be quicker and Resident #1 agreed to have a bath that day.

Review of Resident #1's plan of care: ADL Assistance last updated November 2013:

The plan of care for Resident #1 has explicit instructions on how the Resident is to be transferred via mechanical lift and bath slings on bath days.

Interview with Staff #103 on July 7, 2014 at 13:30hrs:

Staff #103 indicated that Resident #1's fall occurred partly because the staff that were providing the care to Resident #1 were not overly familiar with Resident #1's usual practice. This lead to the staff using Resident #1's wheelchair instead of using Resident #1's commode as staff felt that the wheelchair was the safer option for transferring the resident.

Review of progress note from the date Resident #1 experienced a fall indicated that staff were transferring Resident #1 to and from the tub-bath room by use of Resident #1's wheelchair which is not the recommended mode of transferring as outlined in the plan of care on days Resident #1 has a bath. [s. 6. (7)]

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 care set out in Resident #1's plan of care is provided to Resident #1 as specified in the plan., to be implemented voluntarily.

Issued on this 22nd day of July, 2014

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