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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2014	2014_292553_0024	743-13,1044 -13	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 TERRACES
600 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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 23,24,25 2014

Logs O-000743-13 and O-001044-13 were addressed during this inspection

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Manager, Resident Care Coordinator (RCC), Registered Social Worker (RSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents

During the course of the inspection, the inspector(s) toured the home, observed care being delivered to residents, reviewed clinical health records, reviewed the home's policies on Responsive Behaviours, Prevention of Abuse and Neglect, Zero Tolerance of Abuse and Reporting of Abuse.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to identify behavioural triggers for Resident #4 when Resident #4 demonstrated responsive behaviours in physically pushing Resident #3.

Regarding Log #743-13

Summary of event related to Log #743-13:

On a specified date Resident # 3 was found lying on their side in the doorway of Resident #3's room by a PSW. When asked what had happened, Resident #3 stated that there had been an incident with Resident #4 that resulted in Resident #3 being found on the floor. Resident #3 was assessed by a RN in the home and was transferred to hospital for further interventions.

Interview with Staff who had cared for Resident #4 prior to the specified date:

Staff #102 indicated that Resident #4 was known to be resistive to care, but not aggressive when being resistive. Staff #102 stated that Resident #4 did not like mornings, one had to approach Resident #4 in a calm manner or Resident #4 would become defensive. Despite the episode of pushing Resident #3, Resident #4 had no prior history of aggressive behaviours.

Resident #4 was known to Staff #104 to be normally pleasant, there were occasions where Resident #4 would become agitated and aggressive. Staff #104 stated that this occurred mostly in late afternoon early evening. According to Staff #104, Resident #4 would escalate their behaviours if a co-resident annoyed them. Staff #104 indicated that the approach that Resident #3 used to remove Resident #4 from Resident #3's bathroom may have caused Resident #4 to respond in the way they did due to being annoyed or provoked by Resident #3.

Review of Resident #4's Care Plan that was in effect.

After the specified date, there was no documented evidence of a responsive behaviour care plan being initiated to reflect the newly displayed potential for aggressive behaviour, which would include identifying possible triggers.

Resident #4 was transferred to a different care area within the home to accommodate Resident #4’s care needs.

Interview with Staff who had cared for Resident #4 after being transferred to the new care area indicated the following:

Staff #105 indicated that Resident #4 has had other physical episodes since moving, Resident #4 has also experienced a near miss of physical aggression as well. Staff #105 stated that often Resident #4 is provoked due to co-residents.
Staff #105 and #106 state that there are current interventions in place to help mitigate potential incidents between Resident #4 and other co-residents. Staff #105 and Staff #106 both indicate that these interventions are effective.[s. 53. (4) (a)]

Issued on this 11th day of August, 2014

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