Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 12, 18, 19, 20, Jun 1, 15, 18, 19, 26, 2012	2012_048175_0009	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 TERRACES
600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Acting Administrator, Director of Resident Care, Registered Nurse, two Registered Practical Nurses, three Personal Support Workers,

During the course of the inspection, the inspector(s) reviewed resident health records specific to the complaint, observed the resident, observed staff:resident interactions with resident # 3,observed the nourishment pass on the identified resident home area reviewed policies and procedures specific to the complaint

The following Inspection Protocols were used during this inspection:

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The Acting Administrator was interviewed April 20, 2012, and indicated the following:
- meeting with the Power of Attorney (POA) of resident #3 to discuss a complaint that resident#4 hit resident #3. (Three related emails provided by the Acting Administrator). It was confirmed that there was no documentation of the type of action taken to resolve the complaint, including date of action, time frames for actions to be taken and any follow-up action required, the final resolution if any, every date on which a response has been provided to the complainant and a description of the response and any response made by the complainant.[Ref. r.101.(2)].

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 a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frame for actions to be taken and any follow-up action required, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Acting Administrator was interviewed and indicated the following:
-meeting with the Power of Attorney (POA) of resident #3 and was made aware of allegations that resident#4 was witnessed by co-resident, to hit resident #3;
-he discussed potential management strategies of resident #4 with the POA of resident #3. The Administrator reported the POA of resident #3 asked him if any of these things were done and the Administrator said he did not know.

2.An RN was interviewed April 20,2012 @12:33 and indicated resident #4 hits out once in a while and is very behavioural.

3.RN progress note on resident #4 health record indicated that -writer was called as resident #4 was seen slapping another resident on the hand. This was witnessed by a family member of another resident, not by staff.

4.Documented incident on Health Care Record of Resident #4 reviewed: Aggressive Behaviour- A co-resident reported that resident #4 has shaken the walker when the co-resident attempted to walk down the hallway.

5.RPN was interviewed and reported: I heard that resident #4 had gone up and smacked resident #3. The incident might be on the chart of resident #4 but there is not a whole lot in place that we can do. Management is well aware.

6.Care Plan of Resident #4 reviewed: Behaviour Problem identified on care plan did not include slapping of co-residents or shaking the walker of a co-resident attempting to ambulate and/or interventions to manage the behaviours [Ref/ s.6(10 (b)].

The licensee failed to ensure that resident #4's behaviours were re-assessed and the plan of care was reviewed and revised when resident #4 was confirmed by staff, to slap other residents and to shake the walker of a co-resident attempting to ambulate in the hallway.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Email reviewed from the Acting Administrator to the Director of Care, included the following:
-POA of resident #3 spoke to me today and is upset that resident #4 hit resident #3. The POA wants to know what actions we plan to do to help prevent this in the future.Another identified resident in the same resident home area told the POA, resident #4 hits her as well.

Email from Resident Care Co-ordinator to Director of Care, copied to the Administrator...For the record, there is no incidence of resident #4 hitting resident #3 or other residents that I could find.

RN interviewed April 20, 2012 indicated Resident #4... hits out- does that once in a while, resident #4 and is very behavioural.

2.Documented incident on Health Care Record of Resident #4 reviewed: Aggressive Behaviour- A resident reported that resident #4 has shaken the walker when co-resident attempted to walk down the hallway.[Ref. s. 23(1)(a)].

The licensee failed to ensure that every alleged, suspected or witnessed incident of resident #4 including hitting/slapping resident #3, hitting co-resident on the same resident home area, or shaking the walker of another co- resident when the resident was trying to walk down the hallway, was investigated.

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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:abuse of a resident by anyone, to be implemented voluntarily.

Issued on this 26th day of June, 2012

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