



**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  
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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 2, 2015	2015_195166_0013	O-002027-15, O-002277-15	Complaint

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### **Licensee/Titulaire de permis**

REGIONAL MUNICIPALITY OF DURHAM  
605 Rossland Road East WHITBY ON L1N 6A3

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### **Long-Term Care Home/Foyer de soins de longue durée**

HILLSDALE TERRACES  
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

CAROLINE TOMPKINS (166)

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## **Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): June 22 and June 23, 2015**

**Critical Incident Log O-002277-15 was inspected concurrently with this complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Resident, Family, Social Worker, Registered Nurse, Registered Practical Nurse, Personal Support Workers, RAI Coordinator, Director of Care and Administrator.**

**During the course of the inspection, the inspector reviewed clinical health records, program/activity information, staffing and observed resident to resident interactions in 2 specific home areas.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.



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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).**

**Findings/Faits saillants :**

1. Log O-002277-15

The licensee has failed to ensure that when required to make a report immediately following an incident, and it is after normal business hours, the report was made using the Ministry's method for after hours emergency contact.

Review of Critical Incident Report(CIR), indicated that three cognitively impaired residents were involved in a physical altercation with each other. Two residents sustained minor injuries, the third resident did not sustain any injuries.

The CIR reporting the incident was received by the Director the day after the incident had occurred. [s. 107. (2)]

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**Issued on this 2nd day of July, 2015**

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

**Original report signed by the inspector.**