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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2016	2016_327570_0005	033242-15	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

SAMI JAROUR (570)

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): February 24, 25 and 26, 2015.

Complaint log #033242-15 related to concerns regarding an allegation of resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Resident Care Coordinator (RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), RAI-MDS Coordinator, Personal Support Worker (PSW), Residents and Family Member.

The inspector also observed staff to residents interactions, reviewed clinical health records, and reviewed the licensee's policy related responsive behaviours and skin and wound care program.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Resident #002 was admitted to the home on an identified date with several medical diagnoses including cognitive decline.

Review of the the most recent RAI-MDS assessment indicated the resident exhibits behavioural symptoms including: wandering, physically abusive behavioural symptoms, socially inappropriate or disruptive behavioural symptoms, and resistive to care.

Review of progress notes for resident #002 indicated the resident exhibited those behaviours on multiple occasions during a seven month period.

Further review of progress notes for resident #002 indicated seven documented injuries to skin described of unknown origin during a seven month period.

Interview with PSW #105 indicated resident #002 exhibits responsive behaviours and that staff will intervene to assist the resident.

Interview with RN #103 and RPN #102 indicated resident #002 exhibits responsive behaviours and that staff will try to redirect the resident if the resident is not resistive or upset when approached.

Review of the current care plan for resident #002 does not indicate that the resident exhibits any of the behaviours documented in the progress notes and behaviours reported by staff with no documented strategies in place to respond to those behaviours; furthermore, the care plan does not include any strategies to manage potential injury to self or others when resident #002 is noted by staff to have injuries to skin described of unknown origins.

Review of resident #002's care plan with RAI-coordinator RPN #106 and RN #103 both indicated the expectation is that care plan for resident #002 should identify responsive behaviours and should include strategies to respond to the resident's behaviours. [s. 53. (4) (b)]

2. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Resident #001 was admitted to the home on an identified date with several medical diagnosis including cognitive decline.

Review of the most recent RAI-MDS assessment indicated the resident exhibits behavioural symptoms including: wandering, physically abusive behavioural symptoms, and socially inappropriate or disruptive behavioural symptoms.

Review of progress notes for resident #001 indicated the resident exhibited those behaviours on multiple occasions during an identified seven month period.

Interview with registered staff and personal support workers staff indicated resident #002 exhibits responsive behaviours. PSW #100 and #105, both indicated resident #001 is not aggressive toward co-residents.

Review of the current care plan for resident #001 does not indicate that the resident exhibits any of the behaviours documented in the progress notes and behaviours reported by staff with no documented strategies in place to respond to those behaviours.

Review of resident #001's care plan with RAI-coordinator RPN #106 and RN #103, both indicated the expectation is that care plan for resident #001 should identify responsive behaviours and should include strategies to respond to the resident's behaviours. [s. 53. (4) (b)]

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 by ensuring strategies have been developed and implemented to respond to responsive behaviours demonstrated by residents #001 and #002 or any other resident, to be implemented voluntarily.

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.