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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2017	2017_603194_0025	008343-17	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), JENNIFER BATTEN (672), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 2, 3, 6, 7, 8 & 9, 2017

The following concerns were inspected concurrent with Resident Quality Inspection, Logs #030289-16, #011037-17, #011712-17, #011759-17, #014346-17 for resident to resident abuse, Log #012553-17, for resident fall, Logs #021063-17, #013277-17, #019448-17 for resident care issues

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Administrator, Director of Care (DOC), Resident Care Coordinators (RCC), Registered Dietitian (RD), Registered Physiotherapist (PT), Rai Coordinator, Physician, Representative of Resident and Family Councils, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW)

The inspectors completed a tour of the resident home and common areas, observed infection control and medication practices, staff to resident provision of care, spoke to Family and Resident Councils, reviewed policies related to falls, prevention of abuse and clinical health records of identified residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #002 provided clear directions to staff and others who provided direct care to the resident, related specifically to falls prevention.

Resident #002 was independent with transferring, walking, had a steady gait, and utilized a wheeled walker for mobility. The clinical health record indicated that resident #002 was a medium falls risk, and had sustained five falls within a one month period, one of which resulted in injury.

Review of the written plan of care for resident #002 identified two interventions in place; that commonly used articles were to be kept within easy reach, including the call bell, and to maximize proper lighting.

During an interview with inspector #672 on November 6, 2017, PSW #113 indicated that staff were implementing several interventions for resident #002 specific to falls prevention, which included observations every 30 minutes, ensuring resident was

utilizing the wheeled walker, was wearing appropriate footwear, and a motion sensor was activated on the wall beside the bed.

During an interview on November 6, 2017, the DOC indicated the expectation was that the written plan of care for resident #002 was updated to provide clear direction to all staff providing direct care.

The licensee failed to ensure that the falls written plan of care for resident #002 provided clear directions to the staff providing direct care to the resident, when interventions identified by PSW #113 were not included within the written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #023 collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Log # 019448-17 and # 021063-17

Resident #023 required 2 staff total assistance for continence care.

A review of the progress notes for resident #023 was completed for the period of an identified month.

On an identified date the progress notes indicated that resident #023 complained of discomfort and the family requested a diagnostic test be completed.

Three days later, the diagnostic test for resident #023 was obtained, the test indicated that the results were available three days later and a Physician's order was received nine days after the test was obtained.

The progress notes for the period of 12 days were reviewed, identify that resident #023 was symptomatic during the identified period. A number of requests were made by the residents family related to the status of the diagnostic test obtained.

During interview with Inspector #194 on November 6, 2017, DOC indicated that there was no explanation for the delay in treatment for resident #023's condition.

There is no evidence of any collaboration within the interdisciplinary team related to the processing of the diagnostic test completed for resident #023, resulting in a delay in

treatment for the resident. [s. 6. (4) (a)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.