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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2019	2019_694166_0007	025599-17, 026553-17, 028640-17, 005749-18, 018385-18, 018439-18, 020874-18, 021065-18, 022251-18, 026203-18, 030274-18, 000454-19, 001676-19, 003470-19	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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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): March 11, 12, 13, 14, 18, 20, 21, 22, 25, 26, 27, 28, 29, April 1, 2019

Complaint logs # 025599-17, 028640-17, 026553-17, 018385-18, 021065-18, 005749-18, 018439-18, 020874-18, 022251-18, 003470-19, 026203-18, related to resident care, 020840-17, 028028-18, related to responsive behaviours, 030274-18, related to bed refusal, 001676-19 and 000454-19, related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Physiotherapist (PT), Wound Care Nurses, Resident Assessment Instrument Coordinators (RAI), Environmental Supervisor (ES), Resident Care Coordinators (RCC), Director of Care (DOC) and the Administrator.

During the course of this inspection, the Inspectors, toured specific resident rooms, common areas, observed interactions between staff and residents, resident to resident interactions, reviewed clinical documentation, the licensee's policies relevant to this inspection, the licensee's complaint process and the licensee's investigations documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Related to Log #005749-18

A complaint was submitted to the Director expressing concerns related to a medication that the physician had prescribed and was to be administered to resident #002 without discussion or the consent of resident #002's Substitute Decision Maker (SDM).

Review of resident #002's physician's order, indicated the physician had ordered a specific medication to be administered daily to resident #002. The effectiveness of the medication was to be reassessed at a specific time. Medication Administration Records (MARS) indicated the medication was initiated and administered on a specified date. The medication was discontinued a number of days after the first administered dose.

During an interview with Inspector #166, resident #002's SDM confirmed, they were not notified of the Physician's order or the administration of the medication prescribed for resident #002.

During an interview with Inspector #166, the Resident Care Coordinator (RCC) #105, review of resident #002's MARS and the licensee's documentation, confirmed that

resident #002's SDM was not notified of the physician's order or the administration of the medication that had been prescribed for resident #002.

During an interview with Inspector #166, RN#110, who had received the physician's order, confirmed that resident #002's SDM was not notified of the physician's order related to prescription of the specified medication, which had been administered to resident #002.

Interviews with RCC #105, RN #110, resident #002's SDM and review of clinical documentation confirmed that resident #002's SDM was not given an opportunity to participate fully in the development and implementation of resident’s #002's plan of care related to the prescribed medication.

The licensee has failed to ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident SDM are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. [s. 6. (5)]

2. Related to Log 020874-18

A complaint was submitted to the Director, related to the implementation of interventions in order to mitigate injury from falls for resident #002.

Review of the documentation and during an interview with Inspector #166, resident's SDM, indicated, that resident #002 had fallen a number times during a three month period. The SDM indicated the resident had a history of falls and had requested that certain interventions be put in place to reduce the injury from falls.

Review of resident #002's clinical records indicated resident #002 was designated a high risk for falls, although the resident was independent with mobility. Review of resident #002's plan of care related to falls indicated several interventions to mitigate falls and injury from falls.

Review of the documentation related to the first care meeting held on a specified date, indicated the resident's SDM spoke with the Director of Care (DOC) related to the falls and the interventions that were to be put in place to mitigate injury from falls.

During an interview with Inspector #166, the DOC, indicated that after the meeting with

resident #002's SDM, the SDM agreed to the use of a specific apparatus to mitigate injury from falls.

Review of the documentation related to a second care meeting, with resident #002's SDM, the DOC and RCC #105, indicated that on the date of the second care meeting, resident #002 sustained a fall. There were no injuries to the resident. Documentation indicated the specific apparatus used to reduce injury from falls was in the resident's room but was not in place.

The intervention related to the use of the specified apparatus to reduce injury from falls was discussed and agreed upon with resident's SDM during the first care meeting but had not been implemented until after the resident sustained a fall on the date of the second care meeting.

The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan. [s. 6. (7)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Related to Log # 026553-17

A complaint was submitted to the Director, related to the dignity and privacy of resident #004. Review of the complaint documentation indicated, that while visiting a co-resident, the complainant witnessed, resident #004, displaying identified resistive and responsive behaviours in view of co-residents and visitors. Documentation indicated, the situation continued for approximately 15 minutes, before staff removed the resident from the area.

Review of the licensee's investigation documentation, indicated that the licensee had verified, that a lack of dignity was demonstrated towards resident #004.

During an interview with Inspector #166, the Administrator confirmed the incident related to resident #004 did not provide the resident with courtesy and did not respect resident #004's dignity.

The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. [s. 3. (1) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Related to log #003470-19

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the licensee's policy INTER-03-10-01 Pain Management -December 14, 2018. indicates:
Registered Staff (RN/RPN) will:
2. If pain is identified, collaborate with resident/SDM (if applicable) and interdisciplinary team to conduct a pain assessment utilizing a clinically appropriate tool.

A complaint was received from resident #006's Substitute Decision Maker. The complainant expressed concern related to several issues of care for resident #006, including the management of pain for resident #006.

Review of the complaint documentation indicated, the complainant expressed concerns that resident #006, experienced discomfort and pain related to skin breakdown.

During an interview with inspector #166, resident #006 indicated experiencing discomfort and pain in specific areas of the body. Inspector #166 reported the resident's discomfort to RPN #122, who indicated the resident had received the regular administration of an analgesic but would assess the resident and administer the breakthrough analgesic if required.

During an interview with Inspector #166, RPN #122, indicated when the regularly administered analgesic effectiveness decreases, resident #006 does experience

discomfort, often related to skin breakdown. RPN #122, indicated this discomfort often occurs just as it is time for the next administration of the regular analgesic. RPN #122 indicated, perhaps the timing for the administration of the regular analgesic is a reason that the resident has not required many as needed analgesics.

Review of the MAR for one specific month, indicated the resident had received two doses on two separate days of the as needed analgesic. Review of the MAR for the following month, indicated the resident had not required any as needed analgesic.
For added comfort, interventions documented in the resident's plan of care and observation, indicated resident #006 had use of a therapeutic surface and was repositioned while in bed. A support ensured the resident remains on their side when in bed and when the resident was seated in the chair, a therapeutic cushion was used for comfort.

Inspector #166 and RAI Coordinator #123, reviewed resident #006's clinical records but were not able to locate any documented evidence of a recent pain assessment that had been completed for resident #006. The last documented pain assessment for resident #006 was completed a number of months prior to this inspection.

Since the date of the last pain assessment, no further pain assessments had been completed even though the resident continued to express discomfort and the physician had made several changes to the analgesics that resident #006 received.

The licensee has failed to ensure that the licensee's policy INTER-03-10-01 Pain Management -December 14, 2018. which indicated, the Registered staff (RN/RPN) will: If pain is identified, collaborate with resident/SDM (if applicable) and interdisciplinary team to conduct a pain assessment utilizing a clinically appropriate tool, was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Related to Log #018439-18

During an interview with resident #002's SDM and review of the SDM's complaint that had been submitted to the Director, indicated on a specified date, resident #002 was observed in a non-resident area.

Clinical documentation, indicated resident #002 was independently mobile and was able to wander within the home area.

During an interview with Inspector #166, the Environmental Supervisor (ES), indicated on a specified date, the ES was in their office when they noticed that a resident had walked past.The ES checked the resident's ID bracelet and brought the resident, who was unharmed, back to their home area. When the resident was asked how they got to the restricted area, the resident responded, that they had taken the elevator. The resident's family was notified of the incident.

After the incident, the elevator was checked to determine how a resident could get onto to the service elevator and get to the non-resident area without the use of a key fob, as the service elevator is restricted for resident use. Through the licensee's investigation it was determined that a staff (unknown) pushed the service elevator button from the floor resident #002 resides, swiped the key fob for the elevator to open and then decided to take the stairs, leaving the elevator doors to open and which allowed resident #002 to

enter and end up in a non-resident area.

During an interview with Inspector #166, the ES, indicated, that after the incident of finding resident #002 in the non resident area, the timing for service elevator door closure was reduced from 30 seconds to 15 seconds. A memo from the Administrator was posted and distributed to staff by email, notifying staff of the incident and advising staff when calling the service elevator to a floor to remain with elevator and not take the stairs. Review of the licensee's Health and Safety minutes also addressed the incident and the memo advising staff when using the service elevator to remain with elevator when the doors opened.

On the date of the incident, an unknown staff member unlocked the service elevator and then left the elevator unsupervised when the doors opened, allowing resident #002 access to a non-resident area.

The licensee has failed to ensure that the following rules are complied with, that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. related to Log #030274-18

The licensee has failed to ensure that when withholding approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care; an explanation of how the supporting facts justify the decision to withhold approval; and contact information for the Director. 2007, c. 8, s. 44 (9).

A complaint by the Central East Local Health Integration Network(CELHIN), placement, related to a bed refusal to this Long Term Care Home was submitted to the Director.

Review of the licensee's response to the application for admission indicated the applicant was declined, citing that the home lacked the nursing expertise necessary to meet the applicant's requirements, but did not provide details related to how the home lacked the nursing expertise that would be required for the care of this identified applicant as the response letter clearly stated that the applicant’s condition was stable at the time of the application.

The licensee has failed to provide a detailed explanation of the supporting facts, as they relate to both the home and to the applicant’s condition and requirements for care and how the supporting facts justify the decision to withhold approval for admission to the specified applicant. [s. 44. (9)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;   O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Related to log #004370-19

A complaint was received from resident #006's Substitute Decision Maker(SDM). The complainant expressed concern related to several issues of care for resident #006, which included the management of continence for resident #006.

Interviews with resident #006 and the resident's SDM indicated, the resident maintained that they had the ability to recognize the need for the elimination of bowel and bladder and was able to use the toilet/commode.

During an interview with Inspector ##166 and review the physical assessment related to the safety of the resident completed by the Physiotherapist (PT), the PT indicated the resident was unsafe to use the toilet or the commode due to an identified diagnosis.

Review of the licensee's policy related to Continence Care and Bowel Management INTERD-03-07-01 (revised October 2018) states:
Each resident who is incontinent receives an assessment that includes casual factors, patterns, type of incontinence and the potential to restore function with specific interventions and where the condition or circumstances of the resident require, an assessment is used conducted using a clinically appropriate assessment instrument that

is specifically designed for assessment of incontinence.

During interviews with Inspector #166 and review resident #006's clinical records ,Registered staff and RAI Coordinator #123 were not able to locate any documented evidence that an assessment of resident #006 ability related to continence had been completed when resident #006's continence ability had changed.

The licensee has failed to ensure that,each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

Issued on this 17th day of April, 2019

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

Original report signed by the inspector.