Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 6, 2020 | 2020_598570_0010 | 001253-20, 001254-20, 013640-20, 018161-20, 018706-20 | Critical Incident System |

### 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 Estates
590 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 Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 21, 22, 23, 24, 28, 29 and 30, 2020.**

**The Critical Incident System inspection included two logs related to follow up of two compliance orders and three logs related to allegations of abuse.**

**During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Resident Care Coordinators (RCC), Environmental Services Manager (ESM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.**

**The inspector also toured residents' home areas, observed resident to resident interactions and staff to residents interactions, reviewed residents' health care records, reviewed investigation notes and relevant policies.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 15. (1) | CO #002 | 2019_643111_0021 | 570 |
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2019_643111_0021 | 570 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Légende |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 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:**
**3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #003's right not to be neglected by the licensee or staff was fully respected and promoted.

A Critical Incident Report (CIR) indicated that Personal Support Worker (PSW) #105 did not toilet resident #003 upon resident's request. The plan of care for the resident directed that the resident to be toileted at certain times and as needed.

PSW #105 verified that they did not toilet the resident when the resident requested and indicated the resident was able to express their needs regrading toileting.

Resident Care Coordinator (RCC) #110 and the Acting Director of Care (ADOC), they verified that resident #003's right not to be neglected was not fully respected and promoted by PSW #105 when the PSW did not toilet the resident as requested.

Sources: Critical Incident Report (CIR), the written plan of care for resident #003, the homes internal investigation, interviews with resident #003, PSW #015, RCC #110 and the Acting DOC and other staff. [s. 3. (1) 3.]

***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 resident right not to be neglected by the licensee or staff was fully respected and promoted, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with related to immediate reporting on an incident of abuse involving resident #005.

Review of the home's "Abuse and Neglect-Prevention, Reporting & Investigating" policy directed that an employee who is advised or has first-hand knowledge of abuse and/or neglect or suspected abuse and/or neglect must immediately inform their supervisor/designate or the Registered Nurse (RN) or Registered Practical Nurse (RPN) on duty.

PSW #111 reported to RCC #113 and RCC #114 that they witnessed abuse toward resident #005 by PSW #107 after one month from the date of the witnessed incident. While providing care to the resident, PSW #107 was rough with the resident causing the resident to scream. Rough handling puts the resident at potential risk for injury. RCC #113 verified that PSW #111 who witnessed the incident did not immediately report that to their supervisor.

The Acting DOC verified that staff should immediately report any suspicion of abuse to their supervisor and that PSW #111 did not follow the home's policy.

Sources: CIR, the homes internal investigation, Abuse and Neglect-Prevention, Reporting & Investigating policy (ADM-01- 03-05) reviewed March 2019. Interviews with RCC #113 and the Acting DOC. [s. 20. (1)]

***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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.***

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**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:**

**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; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(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. The licensee has failed to ensure that alleged or witnessed incident of abuse involving resident #005 was immediately investigated.

PSW #111 reported to RCC #113 and RCC #114 that they witnessed abuse toward resident #005 by PSW #107 after one month form the date of the witnessed incident. While providing care to the resident, PSW #107 was rough with the resident causing the resident to scream. The incident was not immediately investigated.

RCC #113 verified that the investigation was initiated after one week of being notified of the incident. The RCC indicated that the allegation of abuse involving resident #005 should have been immediately investigated when reported by PSW #111.

The Acting DOC verified that the allegation of abuse was not immediately investigated as RCC #114 was supposed to submit a CIR for the incident and initiate an investigation but they did not.

Sources: CIR, the homes internal investigation, interviews with RCC #113 and the Acting DOC. [s. 23. (1) (a)]

***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 abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #005 by PSW #107, that resulted in a risk of harm, was immediately reported to the Director.

A review of the CIR and the licensee's investigation documents indicated that the alleged incident of abuse of resident #005 by PSW #107 was not immediately reported to the Director by RCCs #113 and #114.

Acting DOC and RCC #113 verified that the allegation of abuse was not immediately reported as RCC #114 was supposed to submit a CIR for the incident but they did not.

Sources: CIR, the homes internal investigation, interviews with RCC #113 and the Acting DOC. [s. 24. (1)]

***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 person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #005's substitute decision-maker (SDM) and any other person specified by the resident, were immediately notified upon becoming aware of an alleged incident of abuse of the resident.

PSW #111 reported to RCC #113 and RCC #114 that they witnessed abuse toward resident #005 by PSW #107 after one month from the date of the witnessed incident. While providing care to the resident, PSW #107 was rough with the resident causing the resident to scream.

RCC #113 indicated that they became aware of allegation of abuse involving resident #005 after one month of the date of the incident and that the SDM for resident #005 was not immediately notified of the incident.

Acting DOC verified that the SDM for resident #005 was not immediately notified of the incident.

Sources: CIR, the homes internal investigation, interviews with RCC #113 and the Acting DOC. [s. 97. (1) (a)]

***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's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.***

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**Issued on this 15th day of October, 2020**

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

**Original report signed by the inspector.**