Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: October 9, 2025
Inspection Number: 2025-1559-0007
Inspection Type:
Complaint
Critical Incident

Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 29, October 1 - 3 and 6 - 9, 2025

The following intake(s) were inspected:
- Intake: #00155697 - Critical Incident (CI) #M539-000067-25 - related to sexual abuse of a resident by another resident.
- Intake: #00155711 - CI #M539-000068-25 - related to fall of a resident.
- Intake: #00155746 - Complainant related to an injury of unknown origin for a resident
- Intake: #00156295 - Complainant related to retaliation
- Intake: #00157485 - CI #M539-000073-25 - Physical abuse of a resident by staff.
- Intake: #00157702 - CI #M539-000077-25 - Improper care of a resident.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee failed to protect a resident's right to be free from neglect when registered staff failed to ensure that the resident was reassessed weekly for altered skin integrity,

Ontario Regulation 246/22, s. 7, defines "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident sustained an injury. A critical incident report was not submitted to the Ministry, and no cause for the injury was identified, as an investigation had not been completed.

Sources: Clinical progress notes for the resident, Home's investigation records.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)
Licensee must investigate, respond and act
s. 27 (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;

A critical incident report was submitted to the Director regarding a sexual abuse incident involving two residents. During the record review, it was noted that one of the residents had previously been involved in another sexual abuse incident that was not reported to the Director. A review of the resident's progress notes and an internal incident report created by a Registered Nurse (RN) documented the event, but there was no evidence that the home investigated the incident or took any action in response.

Sources: The Resident's clinical records.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

1-The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director. Specifically, a complaint was received alleging that the Resident sustained an injury. A critical incident report was not submitted to the Ministry.

Sources: Complaint and interview with a Resident Care Coordinator.

2-The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director. Specifically, an alleged physical abuse of the resident reported the incident to the Director two days after the occurrence.

Sources: A Critical Incident Report.

3-The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director. Specifically, an alleged physical abuse of the resident was reported to a Registered Practical Nurse (RPN) on the day of occurrence and the home reported the incident to the Director four days late.

Sources: A Critical Incident Report and interview with an RPN.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident. Specifically, during repositioning, the resident sustained an injury.

Sources: Incident Report - General Incident, and interview with a Personal Support Worker.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, received a skin assessment using a clinically appropriate assessment instrument. Specifically, the resident exhibited altered skin integrity, which was not assessed or documented as required.

Sources: Incident Report - General Incident, the Resident's Health Record, and interview with a Registered Practical Nurse.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a Resident was reassessed weekly for altered skin integrity. The resident had documented injuries to multiple areas. A review of clinical records showed that no weekly skin assessment note was completed for a period of time, despite the clinical indication.

Sources: The Resident's Clinical progress notes.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee failed to ensure that a resident's behaviour was consistently monitored and documented using the home's Dementia Observation System (DOS). Although DOS tracking was initiated on multiple occasions, all data collection sheets were incomplete or missing. Additionally, there was no evidence that the data collected in a specific month was analyzed to identify behavioural patterns.

Sources: The resident's clinical record, DOS data collection tool, interview with the BSO RPN.

COMPLIANCE ORDER CO #001 Plan of care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1-The Director of Care (DOC) or designate is to provide in-person education to two Personal Support Worker (PSW) on the importance of following and implementing the plan of care related to feeding precautions for residents with dysphagia and aphasia.
2-The DOC or designate must ensure that the following are documented: The date of education was provided, the name of the person who delivered the education, and the names and signatures of the staff who completed the education.

Grounds

1-The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan. The resident's plan of care specified a falls prevention strategy which was not implemented when the resident fell down.

Sources: The resident's care plan and Incident Report – Falls.

2-The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.
The resident's plan of care included feeding precautions which was not implemented to

the resident in a specific date causing the resident to be transferred to a hospital and subsequently passed away.

Failure to follow the plan of care contributed to a serious adverse outcome, caused the resident to be transferred to the hospital and subsequently passed away.

Sources: The resident's plan of care, A Critical Incident Report, Long Term-Care investigation notes, and Interview with a registered dietitian.

This order must be complied with by November 19, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.