Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2017_322156_0002	000213-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

CAROL POLCZ (156), LESLEY EDWARDS (506), LISA VINK (168), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 18, 19, 20, 23, 24, 25, 26, 30, 2017.

During this inspection, the inspections listed below were conducted concurrently:
Critical Incident Inspections
017168-16 related to falls prevention
020310-16 related to falls prevention
031682-16 related to falls prevention
033658-16 related to safe transferring
Complaints
02577-16 related to continence
032286-16 related to care concerns

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care, registered nursing staff, wound care registered nurse, Personal Support Workers (PSWs), Food Services Manager (FSM), Environmental Services Supervisor (ESS), Occupational Therapist (OT), residents and families.

During the course of the inspection the inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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)

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. (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 failed to ensure resident #023's written plan of care set out the planned care for the resident.

Progress notes and interview with the DOC on January 25, 2017, confirmed that resident #023's used identified fall prevention interventions due to the resident's history and risk of falls. Review of the resident's documented plan of care did not include the use of the falls prevention interventions. The DOC confirmed the resident's plan of care did not include the planned care for the resident related to falls prevention. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #015 was observed to have one quarter length bed rail in the 'down' position. The plan of care for bed mobility and transfers for this resident indicated that the resident was able to turn and reposition independently and used a quarter length bed rail for support. The plan of care for PASD (Personal Assistive Services Device) indicated that the resident used quarter length bilateral side bed rails applied to promote resident independence. Interview with the resident's family on January 23, 2017, as well as PSW #102 confirmed that the resident only used one quarter length bed rail for repositioning. The PSW confirmed that the plan of care was not clear to staff and others who provide direct care to the resident.

B) Review of plan of care for resident #023 indicated that the resident was to use a wheelchair for locomotion. In another area of the plan of care it indicated that the

resident was to use a wheeled walker for ambulation. Review of the progress notes indicated that the resident had been using the wheelchair at all times. Interview with the DOC on January 24, 2017, confirmed that the resident’s plan of care did not provide clear direction to staff and others who provided direct care to the resident.

C) The plan of care for resident #040 identified, under bladder incontinence that they required a brief during the day, evening and night shift and to toilet them routinely; however, under the focus statement for risk of pressure sores it noted that the resident used a liner, as an incontinent product and was to be assisted with toileting and pericare as needed.
The resident was observed to be toileted by PSW #117 on January 24 and 25, 2017. The PSW identified that resident #040 wore a brief at all times and that they routinely toileted the resident upon rising and at a specified time daily.
A review of the plan of care by RPN #115 and the DOC verified that the plan did not give clear directions to staff related to the incontinence products used by the resident nor clear direction related to their individualized plan for toileting times.
The plan of care did not set out clear directions to staff and others who provided direct care to the resident.

D) The plan of care for resident #014 identified under the focus statement for assistance with activities of daily living that they were to be toileted as per the facility protocol as they did not always tell staff when they had to use the bathroom, under the focus statement for bowel and bladder continence that staff were to routinely toilet the resident and provide good pericare and under the focus statement for risk of altered skin integrity that staff were to respond to toileting requests as soon as possible and to routinely toilet the resident every morning, before and after meals and as needed.
The resident was monitored for toileting during various times on January 20, 24 and 25, 2017.
PSW staff #121 and #114 were observed to offer to take the resident to the bathroom on January 24 and 25, 2017, and both identified that they attempted to toilet the resident before and after each meal on the day shift.
Interviews with the resident on January 24 and 25, 2017, verified that staff provided continence on at least two occasions on the day shifts and other attempts to offer care were refused as they were not needed at the time.
Interview with the DOC and RPN #115 verified that the resident's plan of care did not provide clear direction to staff related to the frequency and timing to toilet the resident based on the three different statements in the plan of care.
The plan of care did not provide clear direction to staff and others who provided direct

care to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in their plan.
The plan of care fore resident #021 under falls prevention directed staff to ensure that falls prevention interventions were in place at all times. On an identified date in May, 2016, the resident fell from their bed and sustained an injury. The investigation notes completed by the home confirmed that the fall prevention interventions were not in place at the time of the fall.
Interview with the DOC on January 24, 2017, confirmed that the staff had not followed the resident's plan of care. [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 written plan of care set out the planned care for the resident, that the plan of care set out clear directions to staff and others who provided direct care to the resident and that care set out in the plan of care was 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #015 was observed to have two bed rails in the 'down' position. The Restraint/PASD Assessments for this resident did not indicate that any alternative to the use of the PASD had been tried, how long the alternatives had been in place, or whether the alternatives had been effective or not. The bilateral quarter length bed rails were noted to be in the resident's plan of care; however, as confirmed by the ADOC on January 24, 2017, alternatives to the use of the PASD had not been tried and had not been effective to assist the resident with the routine activity of living. [s. 33. (4) 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 use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #020 was transferred using safe transferring and positioning techniques.

A review of the home's investigation notes, identified that on an identified date in November, 2016, resident #020 had been injured as a result of actions by PSW #120 during a mechanical lift transfer. The home's policy Mechanical Lifting and Sling Safety protocol directed staff that when a mechanical lift was utilized, two staff members were required to perform the function. At no time was it permissible for only one staff to operate a mechanical lift. PSW #120 confirmed that they operated the lift without the assistance of PSW #123 which resulted in the resident sustaining an injury. Interviews conducted with the DOC and PSW involved in the incident confirmed that safe transferring and positioning techniques were not used on the identified date. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, who was incontinent and assessed as being potentially continent or continent some of the time, received the assistance and support from staff to be continent or continent some of the time.

According to the plan of care, resident #014 was dependent on the assistance of one staff for toileting, was to be toileted routinely and on request and wore an incontinent product as they did not always report to staff the urge to go to the bathroom and was incontinent.
The resident was observed on January 20, 24 and 25, 2017 and was noted to be clean and dry with no evidence of incontinence. PSW staff #114 and #121 verified the provision of continence care on January 24 and 25, 2017, which was supported by interviews with the resident.
Interview with the family of resident #014 identified that on an occasion in August 2016, they visited the resident in the lounge area, when they found that the resident had been incontinent of urine.
The family reported this concern to RPN #115 who directed staff to immediately provide care to the resident, which was completed.
Interview with RPN #115 verified the family members account of the incident and that she had witnessed the status of the resident at the time that it was brought to her attention, although was not able to recall an exact date.
The RPN verified that the resident was dependent on staff to assist with elimination and that on the identified date the resident had been incontinent which was not contained by their undergarments.
The resident did not receive the assistance and support from staff to be continent some of the time or clean and dry. [s. 51. (2) (d)]

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, who was incontinent and assessed as being potentially continent or continent some of the time, received the assistance and support from staff to be continent or continent some of the time, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that training had been provided for all staff who apply PASDs or who monitor residents with PASDs including:
the application of these PASDs, the use of these PASDs, and potential dangers of these PASDs.

As confirmed with the Administrator and ADOC on January 25, 2017, the home had not ensured that all staff who applied PASD bed rails were trained on the application, use and potential dangers for 2016. The home indicated that on a go-foward basis for 2017, the home was including this training in the annual mandatory training for staff. [s. 221. (1) 6.]

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 training has been provided for all staff who apply PASDs or who monitor residents with PASDs including: the application of these PASDs, the use of these PASDs, and potential dangers of these PASDs, to be implemented voluntarily.

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.