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 # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 15, 2016 | 2016_302600_0019 | 033443-16 | 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

Harmony Hills Care Community
1800 O'Connor Drive East York ON M4A 1W7

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

GORDANA KRSTEVSKA (600), SUSAN SEMEREDY (501)

## 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): December 1, 2, 5, 6, 7, and 8, 2016.**

**During this inspection the following complaints were also inspected:**
**Intake #005846-14 related to charges for accommodation and**
**Intake #027466-15 related to cockroach infestation.**

**During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Family and Residents' Council and relevant policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the executive director (ED) , director of care (DOC), registered dietitian (RD), cook, food service supervisor (FSS), housekeeping staff, resident assessment instrument (RAI) co-ordinator, RAI coordinator back-up, office manager, registered nurses (RNs), skin care coordinator, registered practical nurses (RPNs), personal support workers (PSWs), Family Council chairperson, Resident Council president, residents and substitute decision makers (SDMs).**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Resident Charges**
**Residents' Council**
**Skin and Wound Care**

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

**4 WN(s)**
**3 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>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. |

**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:**
**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 ensure that resident #021 had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

Observation conducted on an identified date revealed registered practical nurse (RPN) #104 performed a test and administered a medication to resident #021 in a dining room when the dining room was full with residents and staff.

Review of resident # 021's plan of care revealed the resident had a health condition and an order for a specified test and administering of a medication. Review of the resident's minimum data set (MDS) assessment record for a specified date revealed the resident had moderately impaired cognitive skills for daily decision making and he/she made poor decisions.

Interview with RPN #104 confirmed that he/she performed a test and administered a medication to resident #021 in a common area. The RPN further acknowledged that he/she should not perform those actions in a common area but should have taken the resident to a private area to perform the test and administer the medication.

Interview with the director of care (DOC) confirmed the practice in the home was that staff are to perform an identified test and administer the specified medication in residents' rooms so they respect the residents' privacy and dignity. The staff did not respect resident #021's dignity when he/she performed the test and administered the identified medication in front of all other residents present in the dining room. [s. 3. (1) 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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes resident's individuality and respects resident's dignity, 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. 6. Plan of care**

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

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was revised because care set out in the plan of care had not been effective, different approaches been considered in the revision of the plan of care.

Resident #005 was triggered by staff interview in stage one of the RQI inspection for an impaired skin integrity.

Review of resident #005's MDS dated on an identified date indicated the resident had an area of impaired skin integrity.

Review of resident #005's weekly skin assessment records for identified months in 2016, revealed the resident had impaired skin integrity identified on a specified date. The physician had ordered a treatment plan for skin and wound care. Further review of the weekly skin assessments for resident #005 indicated during an identified month the wound had been deteriorating based on measurements. The measurement from the

following assessment indicated the wound measured a specified measurement. On the next assessment, the wound measurement size had increased. Review of the physician orders indicated the treatment order from an identified date had not been changed.

Interview with skin care nurse #100 confirmed resident #005’s wound had been deteriorating at some point during an identified month, and the resident's plan of care had not been revised as they found the resident to be non-compliant with the interventions.

Interview with the DOC confirmed staff are expected to perform weekly skin assessments and to evaluate of the effectiveness of the treatment and interventions. If the treatment was not effective, the staff should have considered other options and revised on the resident's plan of care. [s. 6. (11) (b)]

2. Resident #001 was triggered by staff interview and census record review in stage one of the RQI inspection for impaired skin integrity.

Review of resident #001’s MDS dated on an identified date, indicated the resident had an area of impaired skin integrity.

Review of resident #001’s weekly skin assessment record revealed the resident had been admitted with impaired skin integrity. The resident had been referred to a physician and treatment had been provided. Resident #001 was assigned to have weekly skin assessments.

Review of resident #001's written plan of care revised on specified date, revealed one of the intervention for skin care was to turn and reposition resident #001 at least every two hours and more often as needed or requested.

Review of the resident's weekly skin assessment for identified months in 2016, revealed the weekly skin assessment on identified dates, indicated the resident's wound had been deteriorating according to the measurements.

Interview with a resident assessment instrument (RAI) coordinator #106 revealed resident #001 was non-compliant with turning and the repositioning program as he/she always turned on his/her back.

Interview with skin care coordinator #100 revealed resident #001 was non-compliant with a turning and repositioning intervention which contributed to worsening of the impaired

skin integrity even though they tried different medical treatments. Further the skin care coordinator confirmed that he/she did not revise the plan of care for the resident's impaired skin integrity and did not consider different approach or interventions.

Interview with the DOC confirmed the practice in the home was for staff to evaluate the effect of the intervention, consider different approaches and to revise the plan of care when the care set out in the plan of care has not been effective. [s. 6. (11) (b)]

***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 was reassessed and the plan of care had been revised because care set out in the plan of care had not been effective, different approaches been considered in the revision of the plan of care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who is dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Resident #005 was triggered by staff interview in stage one of the RQI inspection for impaired skin integrity.

Review of resident #005's MDS assessment dated an identified date indicated the resident had an area of impaired skin integrity. The MDS assessment review also revealed that resident #005 needed extensive assistance by two staff while he/she is in bed. However the MDS assessment record failed to reveal that there was a plan of care for resident #005 to turn and reposition him/her every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load while the resident was in bed.

Review of the resident's weekly skin assessment for identified months in 2016, revealed the weekly skin assessment on identified dates, indicated the resident's wound had been deteriorating according to the measurements. Each of the weekly skin assessments dated above failed to reveal that the resident had been repositioned.

Review of personal support workers (PSWs) daily documentation record for identified months, revealed resident #005 had not been turned and repositioned every two hours or as required.

Interview with the skin care coordinator confirmed the plan of care did not include repositioning of resident #005 to relieve the pressure off the affected area.

Interview with the DOC confirmed the practice in the home is to prevent impaired skin integrity and promote wound healing by turning and repositioning the residents who are high risk or have impaired skin integrity. [s. 50. (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 is dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal complaint.

A complaint inspection was conducted during the Resident Quality Inspection and was related to an intake that was initiated on a specified date. The complainant alleged that there has been an ongoing discrepancy in the accommodation rate for resident #010.

An interview with the complainant revealed that there have been discrepancies in the accommodation charges dating back years. He/she had discussions with someone who is no longer at the home and had also spoken with the person that is currently responsible for resident charges but was not satisfied with the explanation.

An interview with the Office Manager who is currently responsible for billing revealed that resident #010's family member brought the concern related to changes in charges to his/her attention a few months ago. The Office Manager indicated that he/she explained the reasons for resident #010's charges to the family member who did not seem to comprehend the explanation. The Office Manager further revealed that he/she did not document resident #010's family member's concerns as a complaint.

A review of the home's records of complaints for 2014 through to 2016 revealed there was no record of this complaint.

An interview with the executive director (ED) revealed he/she was not aware of this complaint. The ED confirmed that his/her expectation of the home is for staff to bring any unresolved concerns or complaints to the ED for follow-up.

**Issued on this 19th day of December, 2016**

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

**Original report signed by the inspector.**