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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2017	2017_626501_0021	024581-17	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

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

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

SUSAN SEMEREDY (501), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 26, 27, 31, November 1, 2 and 3, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Director of Dietary Services (DDS), Environmental Service Manager (ESM), Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM), Residents' Council President, family members and residents.

The inspectors conducted a tour of the home, observed medication administration system, staff and resident interactions and the provision of care, reviewed clinical health records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.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 all doors that residents do not have access to were kept closed and locked.

•During the initial tour on October 26, 2017, at 0930 hours, the "Clean Utility" room located on the first floor was observed open. The room was accessible to residents and no staff members were observed in close proximity. Inside the clean utility room, inspector #645 observed Provolone Iodine, scissors, eighty five percent full topical antiseptic solution and body shampoo. On November 2, 2017, at 1400 hours the same door was observed open and accessible to residents. Interview with PSW #113 and RPN #112 confirmed that this door should be locked at all times to prevent residents from entering where there are many antiseptics and wound care solutions that would pose a hazard to residents.

•On October 31, 2017, at 1421 hours, the servery door located on the third floor dining room area was observed ajar. The servery room was accessible to residents and there were no staff members in the area at the time. Interview with PSW #114 and RN #115 confirmed that the servery door should be closed and locked at all times to prevent residents from entering. An interview with the Director of Dietary Services confirmed that the servery door should always be locked to prevent residents entering the room where there are many utensils and cleaning solutions that would pose a risk to residents. [s. 9. (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 all doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in different aspects of care of the resident collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Resident #006 triggered from stage one of the inspection from the Minimal Data Set (MDS) for continence care. Record review revealed the resident was admitted to the home on an identified date, and his/her admission MDS indicated he/she was of an identified level of continence. The MDS assessment ninety days later indicated the resident's continence level had changed.

Record review of a progress note revealed resident #006 was admitted to the hospital on an identified date. Upon return from the hospital, the resident's health status and continence level changed. Further review of the plan of care revealed resident #006 was on an identified diet restriction.

An interview with RPN #102 revealed that resident #006 had been very ill during an identified period of time. The RPN noted that in resident #006’s physical chart the physician had discontinued the identified diet restriction. The RPN noted that the written plan of care had not been updated and there was no indication dietary services or the Registered Dietitian (RD) had been informed about this change. The RPN indicated that this is something that he/she would do now.

An interview with the RD revealed he/she had made the recommendation to the physician to discontinue the diet restriction. The RD indicated the process in the home is for nursing to inform him/her of such a change so that he/she can update the plan of care and ensure that the change is implemented by dietary services. The RD confirmed that he/she only received a referral regarding resident #006’s discontinuation of a diet restriction after the inspector spoke with RPN #102.

An interview with the DOC acknowledged that in the above mentioned incident the home failed to ensure the staff and others involved in different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of inspection reports from the past two years are posted in the home.

During the initial tour of the home on October 26, 2017, at 0925 hours, inspector #645 observed one inspection report, #2016_302600_0019 posted on the home's bulletin board located by the front entrance door. This inspection report was placed in the "MOH Report" section of the board and was issued on December 15, 2016. There was no other inspection report observed at the time.

An interview with the DOC revealed that the bulletin board is the only location where the home posts inspection reports and it did not include inspection report, #2015_321501_0009 issued on April 17, 2015 . During the interview, he/she stated that he/she was unaware inspection reports from the past two years needed to be posted.

Interview with the ED confirmed that it is the expectation of the home to post inspection reports from the past two years. [s. 79. (3) (k)]

Issued on this 6th day of November, 2017

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

Original report signed by the inspector.