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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 24, 2019	2019_654618_0020	008004-18, 008836-18, 018229-18, 019171-18, 024389-18, 006641-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

CECILIA FULTON (618), PRAVEENA SITTAMPALAM (699)

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): May 17, 21, 22, 23, 2019.

The following intakes were inspected during this inspection: Log #008004-18, CIS #2832-000002-18, related to responsive behaviours and prevention of abuse, #008836-18, CIS #2832-000005-18, #018229-18, CIS # 2832-000012-18, #019171-18, CIS #2832-000013-18, #024389-18, CIS #2832-000017-18, related to falls prevention, #006641-19, CIS #2832-000004-19, related to injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with The Executive Director, the Director of Care (DOC), Registered Staff (RN/RPN), Physiotherapist (PT) and Personal Support Workers (PSW).

During the course of the inspection, the inspectors observed residents' care areas, and reviewed residents' and the home's records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (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 :

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

The Ministry of Health and Long-term Care (MOHLTC) received a critical incident system (CIS) report in 2018, related to resident #004 who had a fall resulting in injury on an identified date in 2018.

Review of the CIS report indicated that resident #004 had an unwitnessed fall during the night shift on an identified date in 2018. Resident #004 was treated in hospital for injuries incurred as a result of this fall.

Record review of resident #004's progress notes identified a falls history which indicated that resident #004 fell on five occasions during an identified 6 week period in 2018. None of those falls resulted in injury.

Record review of the resident #004's care plan identified several fall prevention strategies in place for the corresponding time period.

In an interview with RN #100, they stated that they would know if fall interventions were effective if there was a reduction in the falls. They further stated that if a fall intervention was not effective they would reassess the plan of care and discuss it with the team to see what more can be done and try another intervention. RN #100 acknowledged that for resident #004, the fall prevention plan of care should have been reassessed and different interventions considered after their multiple falls.

In an interview with the DOC, they stated that at the monthly fall prevention meetings, discussions did take place regarding resident #004's falls status, and that that additional interventions were considered, however review of those meeting minutes undertaken jointly with the DOC and Inspector #699 failed to identify any documentation regarding those discussions or any discussions specific to resident #004.

The DOC acknowledged that for resident #004, the care plan was not reassessed with different approaches as there was no documentation to indicate so.

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

Issued on this 24th day of May, 2019

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

Original report signed by the inspector.