Ontario

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 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
Dec 11, 2019	2019_804600_0024	017294-19, 019463-19, 020281-19, 020310-19	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 TORONTO ON M4A 1W7

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

GORDANA KRSTEVSKA (600)

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): November 27, 28, 29, December 2, 3, 4, 2019.

During this inspection the following Critical Incident System (CIS) reports were inspected:
CIS #2832-000015-19, intake log #: 017294-19, - related plan of care,
CIS #2832-000020-19, intakes log # 019463-19; CIS #2832-000023-19, intake log #020281-19; CIS #2832-000022-19, intake log #020310-19, - related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrative Director (AD), Director of Care (DOC), Assistants of Director of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Behavioural Support of Ontario (BSO) lead.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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. (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 has failed to ensure that the care set out in the plan of care was provided to residents #001 and #004 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to an injury of unknown cause for which the resident was taken to hospital and which resulted in significant change in the resident's health status.

A review of summary of the home's investigation notes indicated probable incident in the room before the resident was found in bed, at an identified time on an identified date. The resident was very confused and they could not recall the incident. Further the investigation notes indicated that the resident was seen by the PSW #101 same shift, in bed, sleeping.

A review of resident #001's plan of care indicated that the resident had change in their health condition. Resident was using assistive device and was independent for an identified activity of daily living (ADL). They had change in another identified condition and were using a specified equipment. Physiotherapy assessment indicated that the resident was unsteady but able to re-balance self without physical support. The resident was identified to be at high risk for incidents related to change of condition and an identified treatment. The plan of care also indicated that the resident's change of the condition affect them to seek assistance when they need it. Planned interventions to prevent incident, among the others was an identified device to be applied when the resident was in bed.

A review of resident #001's daily PSW record titled Documentation Survey Report for an identified dated, indicated no intervention scheduled for the identified device to be applied when the resident was in bed.

An interview with PSW #101 indicated that they were staff on this floor, and they used to work with this resident before. The PSW indicated that they were aware of the resident being at high risk for incident and during a particular shift, they monitored the resident every round to make sure the resident was safe. On the identified date, when they worked on the unit, on their round they noticed resident #001 was in the washroom, with the device beside them. After the PSW assisted the resident, they provided care and walked the resident with the device back to the bed. The PSW indicated that during their shift on the identified date, they did not hear any sound from resident #001's room and they did not see or apply device to the resident when they were in the resident's room. The PSW shared that the resident sometimes is able to remove the device.

In an interview, RPN #103, indicated that resident #001 had changed condition and was

able to do an identified activity independently, but sometimes the change in their condition, prevented them to follow the preventative measures. Further the RPN stated, when they reviewed the plan of care and the effect of the intervention, they still plan to apply the device when the resident is in bed as some times it alerts the staff who react on time to prevent an incident.

In an interview, the Director of Care (DOC) acknowledged that on the identified date, resident #001 did not have the device applied when they were in bed. The DOC stated that the staff was expected to follow the direction set up in the resident's plan of care, and to provide care to resident as indicated in the plan of care. [s. 6. (7)]

2. A CIS report was submitted to the MLTC on an identified date, for an incident that was identified on a specified date for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. Further the CIS indicated that staff identified a skin alteration on the resident's identified body part and was complaining of discomfort when attempted to move. The resident did not have a recent incident and they needed total assistance by an identified number of staff for all ADLs.

Review of the resident Minimum Data Set (MDS) assessment from an identified date, indicated that the resident had change in their health status. They required total assistance by an identified number of staff for all ADLs and used an identified assistive device for a specified ADL related to a specified change. The resident used an assistive device for ambulation and was assisted by others. Resident had not experienced indication of discomfort within the observation period and they were receiving an identified treatment on a regular basis.

A review of resident #004's plan of care indicated that the resident was identified to need total assistance by an identified number of staff in providing care for all ADLs due to change in the health condition and use of the assistive device.

A review of resident #004's daily PSW record titled Documentation Survey Report for an identified period, indicated that the resident received an identified care a day prior the injury was identified and was provided with total assistance of care by an identified number of staff.

A review of resident #004's progress notes indicated that on the identified date in the morning, PSW #111 reported to RPN #109 that resident #004 might have a change in identified body part. The RPN's assessment revealed a skin alteration on the identified

body part. Resident was vocal when tried to move body part. Registered nurse in charge was notified, and the resident was transferred to hospital for further assessment. The resident came back from the hospital the same day with diagnosis of injury of the identified body part and was ordered treatment. Further review of the progress notes indicated that the previous week, resident #004 was complaining of discomfort of another body part; the resident was assessed and an x-ray indicated that there was no injury, only changes predisposing the resident to risk of injury, and the treatments were adjusted.

In an initial interview PSW #107 indicated that they worked on an identified date and shift and they provided an identified care to resident #004. The PSW stated they had assistance by another PSW to provide an identified ADL to the resident, but they were alone when they provided the identified care. The PSW also said that the resident did not complain of any discomfort when they provided the identified ADL, and they did not receive any information that the resident had been having discomfort on the identified body part. During a second interview, PSW #107 changed their statement. They identified resident had a discomfort on the day they worked, when they were getting the resident ready to provide them with the identified care. They reported to the nurse, took the resident back to the room and set them for the shift. The PSW stated that an identified number of staff provided alternative care to the resident, however a review of the home's investigation notes indicate that PSW #107 did not give the resident an alternative care with an identified number of staff.

Further review of the record indicated that on identified dates in the same month, resident #004 was assisted by PSW #107 for the identified care and the care was documented by an identified number of staff providing total care. On different dates within the month, the record indicated that another identified number of staff provided total assistance to resident #004 when provided the identified care.

In an interview, the DOC indicated the home's priority is the staff follow the plan of care when they provide care. In this situation the DOC acknowledged that the staff did not provided care to resident #107 as indicated in the 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 11th day of December, 2019

[redacted]

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

Original report signed by the inspector.