Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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
Feb 14, 2020	2020_520622_0005	000482-20, 000509-20, 000971-20	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

HEATH HEFFERNAN (622), SUSAN DONNAN (531)

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): February 10, 11, 12, 13, 2020

The following logs were completed during this inspection:

Critical Incident intake log #000509-20/Critical Incident System report (CIS) #2832-000001-20 - related to an incident that caused injury to a resident with a hospital transfer and significant change in the resident's health status.
Critical Incident intake log #000482-20/CIS #2832-000002-20 - related to alleged resident to resident abuse.
Critical Incident intake log #000971-20/CIS #2832-000003-20 - related to resident care and services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), the Nurse Practitioner (NP), a Registered Nurse (RN), Registered Practical Nurses (RPNs), the Behavioural Support Ontario RPN (BSO RPN), Personal Support Workers (PSWs) and the residents.

Also during the course of the inspection, the inspectors reviewed the Critical Incident System reports (CIS), hard copy and electronic health records, staff schedules, the licensee's applicable investigation documents, and observed resident care and services.

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. (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 the resident as specified in the plan related to transfers.

Resident #003's plan of care directed staff as follows:
Transfers: resident can weight bear, extensive assistance x2 staff side by side to transfer, may use hoyer lift x 2 staff if resident weak.

On February 12, 2020, during separate interviews with inspector #531, PSWs #105, #106 and #107 told the inspector that resident #003's plan of care specified that the resident required extensive assistance of two staff side by side for transfers at all times.

During an interview RPN #104 told inspector #531 that on January 15, 2020, Resident #003 had sustained injury when PSW #103 transferred the resident from the toilet. RPN #104 further added that PSW #103 had not provided care as specified in the plan as resident #003 required two persons assist with toileting and two persons side by side to transfer.

During an interview with the Director of Care, and review of the critical incident report and internal investigative notes, the Director of Care told inspector #531 that PSW #103 had not provide care as specified during the transfer as resident #003 required a two-person side by side transfer.

The licensee failed to ensure that the care set out in the plan was provided to the resident as specified in the plan. [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 that the licensee shall 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 19th day of February, 2020

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

Original report signed by the inspector.