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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 16, 2017	2017_587129_0008	034881-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

Long-Term Care Home/Foyer de soins de longue durée

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 22, 23, 30, July 20, 2017

This Complaint Inspection log #034881-16 was related to medication administration, continence care, participation of the resident's Substitute Decision Maker (SDM), injury sustained by resident, issues related to nutrition and hydration, provision of care related to a new condition and environmental concerns.
The following Inspections were completed concurrently with this Complaint Inspection: Critical Incident Inspection #2017_587129_0007 and Follow-up Inspection #2017_587129_0006

During the course of the inspection, the inspector(s) spoke with resident family members, Personal Support Workers, Registered Practical Nurses, two Directors of Care, Manager of Environmental Services, Physiotherapist and Registered Dietitian.

During this inspection the inspector toured the home and made observations of the environment, reviewed clinical record documents as well as policies and procedures used in the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

An identified resident's plan of care did not provide clear directions to staff and others who were responsible to provide direct care to the resident when it was identified that care directions included in electronic progress notes were not communicated to direct care staff.

Director of Care (DOC) #608 confirmed that the documents used by direct care staff to identify the care required to be provided to the resident were the Care Plan and the Kardex.

a) Clinical documentation and a diagnostic procedure report provided to the home on an identified date in 2016, indicated that the identified resident had sustained an injury. Clinical documentation made by a registered staff in an electronic progress note the following day, indicated the resident had two devices in place to assist in the management of the injury. Personal Support Worker #602 and #603, who were identified as having provided care to the identified resident at the time of the above noted incident and following the incident confirmed the plan of care had not provided clear direction to them when the documents they used to identify the care requirements of the resident did not contain any information about the injury or what care was to be provided to the resident related to this injury.

b) Clinical documentation made by the Physiotherapist on an identified date in 2016, indicated the resident had sustained minor injury to the lower body. At the time of this assessment the documentation indicated that the Physiotherapist felt that the injury may have been caused by resident movement and the use personal assistive services device (PASD). The Physiotherapist documented that they recommended a specific strategy be put in place in order to prevent further injury.
A review of the Care Plan and Kardex documents that were in place during this period of time confirmed that these care interventions and directions for care where not included in the documents direct care staff used to identify the care requirements for this resident.

DOC #608 and clinical documentation confirmed that the above noted care strategies were not included in the documents that direct care staff used to provide care to the resident and the resident's plan of care did not provide clear direction. [s. 6. (1) (c)]

2. The licensee failed do ensure that the resident, the resident's Substitute Decision-Maker (SDM), if any, and any other person designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

a) The licensee failed to ensure that an identified resident's (SDM) was given the opportunity to fully participate in the development and implementation of the plan of care related to changes in the resident's weight.
Clinical documentation indicated:
-A dietary note made on an identified date in 2016, indicated the resident was assessed related to a significant weight loss.
-A dietary note made on a following identified date in 2016, indicated the resident was assessed related to a significant weight loss and a variable food intake.
-A dietary note made on a following date in 2016, indicated the resident lost 12% of their weight over a 6 month period of time.
-An interdisciplinary Care Plan Review documented on a following date in 2016, indicated the resident's weight had decreased.
-A dietary note made on a following date in 2016, indicated the resident had a weight gain of 4.8%.
-A dietary note made on a following date in 2016, indicated the resident was assessed related to changes in condition and poor intake.
-A dietary note made on a following date in 2016 indicated the resident had lost 8% of their weight over a six month period of time.

There was no documentation at any point during the above noted periods of time that the identified resident's SDM was notified of changes in the resident's weight.

The Registered Dietitian confirmed that they had not notified the resident’s SDM about changes in the resident’s weight and indicated it was the practice in the home that nursing staff would alert SDMs of weight changes. Registered staff #601 confirmed that nursing staff were responsible to alert resident’s SDM of changes in weight and this notification would occur when monthly weight measurements indicated a significant change or a pattern of weight change. Registered staff #601 also indicated notification of weight changes would occur when the resident’s plan of care was reviewed during Interdisciplinary Plan of Care Reviews. Registered staff #601 confirmed that it was the practice in the home that staff would contact the SDM following the above noted review and communicate what was discussed, changes in the resident’s care needs, actions that were being considered to manage the changes and then would document that in the Interdisciplinary Plan of Care Review note.

Registered Dietitian #600 and registered staff #601 confirmed that the resident’s SDM was not given the opportunity to participate fully in the development and implementation of the resident’s plan of care when the SDM was not notified that the resident experienced changes in their weight.

b) The licensee failed to ensure that an identified resident's (SDM) was given the opportunity to fully participate in the development and implementation of the plan of care when they were not notified of, invited to, or provided with an update following Annual Care Conferences held for the resident.
A review of the resident's clinical records confirmed that Annual Care Conferences where held for the resident in 2013, 2014 and 2015.
i) The Social Worker made a clinical note on an identified date in 2013, and indicated that the resident and the resident's family did not attend the Annual Care Conference. There was no documentation in the clinical record made by either the Social Worker or nursing staff that the identified resident’s SDM was notified, invited to or was provided with a follow-up to issues discussed following the above noted Annual Care Conference.
ii) The Social Worker made a clinical note on an identified date in 2014, and indicated that the resident and the resident's family did not attend the Annual Care Conference. There was no documentation in the clinical record made by either the Social Worker or nursing staff that the identified resident’s SDM was notified, invited to or was provided with a follow-up to issues discussed following the above noted Annual Care Conference.
iii) The Social Worker made a clinical note on an identified date in 2015 and indicated

that the resident and the resident's family did not attend the Annual Care Conference. There was no documentation in the clinical record made by either the Social Worker or nursing staff that the identified resident’s SDM was notified, invited to or was provided with a follow-up to issues discussed following the above noted Annual Care Conference.

Director of Care (DOC) #608 confirmed the social worker was responsible to contact the SDM of residents who were scheduled to have care conferences. This contact was made either in person, a letter mailed to an identified address or through a telephone call and it was the expectation that this contact and the reason for the contact would be documented in the resident’s clinical record. DOC #608 also confirmed that if the resident or the resident’s SDM were unable to attend the Annual Care Conference, it would be the expectation that there be communication with the resident and the resident’s SDM following the conference to update them on the discussions, seek input into the care for the resident and this communication would also be documented in the resident’s clinical record. The expectations identified by DOC #608 were also consistent with the general requirements identified in the licensee’s policy “Resident Care and Services Manual – Assessment/Documentation-Plan of Care & Care Plan”, identified as RCS C-15 and last revised on March 31, 2017.

At the time of this inspection DOC #608 was unable to provide any evidence that the identified resident's SDM was notified of, invited to or was provided with a follow-up to the issues identified during the Annual Care Conferences that were held in 2013, 2014 or 2015.

c) The licensee failed to ensure that an identified resident’s (SDM) was given the opportunity to fully participate in the development and implementation of the plan of care when they were not notified that the resident had sustained an injury. The identified resident's SDM confirmed that they had not been notified of the injury sustained by the resident.

DOC #608 and clinical documentation confirmed that following an incident on an identified date in 2016 a diagnostic procedure confirmed the resident had sustained an injury.

DOC #608 and clinical documentation confirmed that staff had not notified the resident’s SDM that the resident had sustained an injury. [s. 6. (5)]

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 and ensuring that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident and the resident's Substitute Decision-Maker (SDM), if any, and any other person designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Long Term Care Home Act 2007 or Regulation 79/10 requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

In accordance with O. Regulation 79/10, s. 30(1) and s. 30(1) 1, the licensee is required to have a written description of the organized programs required under section 8 to 16 of the Long Term Care Home Act2007 that includes its goals and objectives and relevant policies, procedures and protocols.
In accordance with the Long Term Care Home Act 2007, c. 8, s. 8(1) (a) the licensee is

required to ensure there is an organized program of nursing services for the home.

The licensee failed to comply with licensee's procedure "Resident Care and Services Manual-Clinical Records- Discharged/Deceased Resident Clinical Records", identified as RCS H-40, last reviewed on September 30, 2013 when staff in the home were unable to produce an identified resident's discharged clinical record (paper copy), for a period of time in excess of two weeks during the inspection.

The above noted procedure indicated that "records of residents discharged/deceased will be kept in a consistent and orderly manner". The process identified in the procedure for the management of resident records was as follows:
-Upon discharge an order for discharge and an order to destroy or recycle drugs is written by the attending Physician. The Discharge Summary must also be completed.
-The Night Nursing Supervisor/delegate will reassemble the chart and place in overflow file. The chart is to be sent to Nursing Office.
-The Administrative/Nursing Assistant/delegate will assess the record for content and completion, will organize the record into proper order, and will secure the record.
-The completed and secured record will be stored in the "Archives".

Staff in the home failed to comply with the above noted procedure when it was identified that the clinical record for an identified resident, who was discharged from the home, was not available for an extended period of time when requested during an inspection. DOC #608, DOC #609 and registered staff #613 confirmed that the night Nursing Supervisor/delegate had not assembled the chart, placed the chart in the overflow file or sent the chart to the to the Administrative/Nursing Assistant in order to have the chart organized, secured and stored in the archives and as a result staff in the home had not complied with the identified proceedure and had not secured the clinical health record of the identified resident. [s. 8. (1) (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 and ensuring that where the Long Term Care Home Act 2007 or Regulation 79/10 requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

Issued on this 31st day of August, 2017

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

Original report signed by the inspector.