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
Aug 30, 2019	2019_743536_0015	013481-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

CATHIE ROBITAILLE (536)

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): July 19, 23, 24, 25, 31, August 1, 6, 7, 8, 9, 13, 16, 19 and 20, 2019.

The following inspection(s) were completed concurrently with the Complaint Inspection.

Complaints:

013481-19-pertaining to: Skin and Wound Care, Hospitalization and Change in Condition, Continence Care, Falls Prevention and Medication Management.

During the course of the inspection, the inspector(s) spoke with residents, family, personal support workers (PSW's), registered staff, Business Manager, Receptionist, Admission Coordinator, Admission Restorative Services Nurse, Social Worker, Behavioural Support Ontario (BSO) Lead, Nurse Manager, Resident Assessment Instrument-Minimum Data Set Co-Ordinator(RAI-MDS), Convalescent Care Nurse, Clinical Care Coordinator, Director of Care (DOC), Clinical Director of Care (CDOC), Executive Director, Acting Director of Care and Acting Executive Director.

The inspector also toured the home, observed the provision of care and services provided, interviewed staff and residents, and reviewed relevant documents including but not limited to: health care records, training records, staffing schedules, meeting minutes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

On an identified date, a complaint log #013481-19 was called into the Ministry of Long-Term Care Action Line.

Resident #001 was admitted to the home on a specified date, and the admission note identified that the resident had a history of specified altered skin integrity. Resident #001's admission medication orders included but, were not limited to an identified type of medication. No history was received on the actual amount of usage of this medication.

Over the course of a specified number of months, resident's #001 consumption of the specified medication increased. Also, over the course of those months, the resident's family voiced concerns about resident #001 having ongoing altered skin integrity issues.

On a specified date, the physician ordered a referral to an identified specialist. The clinical record for resident #001 revealed that request had been faxed to the specialist.

Almost nine months later, another referral was sent for an appointment for resident #001 to see the specialist.

During an interview with the Nurse Manager staff #109, they confirmed that a follow up had not been done until approximately nine months later, to obtain an appointment with the specialist.

During an interview with registered staff #118, and Nurse Manager staff #109, they confirmed that both the resident and the SDM had, on a number of occasions, voiced that if too much of the identified medication was administered to the resident, their skin integrity would be affected.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective. [s. 6. (10) (c)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, 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 :

The licensee has failed to ensure that where the Act or the Regulation required 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 was required to ensure that the plan, policy, protocol, procedure strategy or system, was complied with.

On an identified date, resident #001's physician documented that a specified medication caused health issues for the resident but, they still needed some usage of the medication and it was to be administered as needed (PRN). The physician ordered to stop the scheduled medication, and continue with the PRN.

A review of the resident's clinical record revealed that the physician's order to discontinue the scheduled medication was not completed, until an identified number of days later.

The home's pharmacy, MediSystem Pharmacy policy titled: "Change of Direction for the Administration of a Medication Policy" issue date: October 1, 2018, document number: MEDI-CL-ONT-035 stated: Procedure-6.1- electronic Medication Administration Record (eMAR) homes: Nursing staff are responsible for discontinuing orders. Discontinue the old order on the eMAR. The new order is entered by pharmacy with the exception of stat or after hours orders.

During an interview with the home's Pharmacist, they identified that on the identified date, an order had not been received, to discontinue the specified medication for resident #001 until an identified number of days later. The Pharmacist also confirmed, that the medication would have continued to be supplied in the pouch dosing system utilized by the home until the order was discontinued. They also confirmed that it was the home's nurses who are responsible to discontinue the medication on the eMAR.

During interview with Nurse Manager #109, they confirmed that resident #001's specified medication order was not discontinued on the identified date, as ordered.

The home failed to ensure that the policy for Change of Direction for the Administration of Medication policy was complied with. [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 the plan, policy, protocol, procedure strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #001 had fallen, the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for falls.

On an identified date, a complaint log #013481-19 was called into the Ministry of Long-Term Care Action Line.

On a specified date, resident #001 a Physio referral and assessment identified that the resident voiced concerns of a potential injury.

On an identified date, the residents' physician visited. Upon review of the physician's notes by the LTC home Inspector, it was noted that there was no mention of resident #001 concerns of an injury. During an interview with registered staff #110 who had been working the day the referral was completed, they told the LTC home Inspector that they would have left a note for the physician in the physician's book. The LTC home Inspector then asked registered staff #110, if the nurse's went on rounds with the physician. Registered staff #110 stated, that unless asked by the physician, the physician just looks in the physician's book, and then they do rounds on their own. When the LTC home Inspector asked if they knew why the physician was not informed of the resident's complaints, and the potential injury if they had left a note for the physician, they stated no they did not.

The LTC home Inspector interviewed registered staff #119, and asked if they recalled an incident that had occurred on a specified date for resident #001, and they stated yes. The LTC home Inspector asked registered staff #119, if the family or resident #001 had reported to them that the resident had a fall, that they had not reported to anyone, and registered staff #119 answered yes. The LTC home Inspector then asked, when it was revealed by the resident that they had fallen, and they did not report it to anyone, was any assessment completed. Registered staff #119 stated, that they had not done the home's required fall assessment.

During an interview, the Director of Care (DOC) confirmed that when resident #001 revealed they had fallen and did not report it immediately, a fall assessment was not completed by registered staff #119. [s. 49. (2)]

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 when the resident has fallen, the resident is assessed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care was based on at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies.

On an identified date, a complaint log #013481-19 was received at the Ministry of Long-Term Care Action Line.

Resident #001 was admitted to the home on a specified date. On admission, resident #001 had specified allergies listed, and more allergies where identified while resident #001 resided in the home.

On a specified date, resident #001 was seen by a specialist. On the report returned to the home from the specialist, they identified an additional allergy.

The LTCH Inspector revealed, that resident #001 did not have the new allergy identified in their clinical record. Nurse Manager staff #109 confirmed that the specialist report had listed an additional allergy. Nurse Manager staff #109 also confirmed, that the allergy had not been entered into the resident's clinical record, and the Pharmacy had not been notified. The home failed to ensure that resident #001's plan of care included all their identified allergies. [s. 26. (3) 10.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon admission.

On an identified date, a complaint log #013481-19 was received at the Ministry of Long-Term Care Action Line.

On a specified date, resident #001 was admitted to the home. A review of the clinical records identified, that the home's admission Head to Toe skin assessment was not completed.

During interview, the Admission Nurse staff #115 confirmed to the LTC home Inspector what their role on admission, and that the identified assessment would have been done by the oncoming shift. During interview with the Nurse Manager staff #109, they confirmed that the admission Head to Toe skin assessment had not been completed. The home failed to ensure that resident #001, received the identified assessment upon admission to the home. [s. 50. (2) (a) (i)]

Issued on this 9th day of September, 2019

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

Original report signed by the inspector.