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 le Loi de 2007 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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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 08, 2016; | 2016_382596_0004 (A1) | 004698-16 | Resident Quality Inspection |

### 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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

BARBARA PARISOTTO (558) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The order has been amended to reflect a change in the resident number, the order and the compliance date.**

**Issued on this 8 day of June 2016 (A1)**

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

**Original report signed by the inspector.**

Ontario

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

BARBARA PARISOTTO (558) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 17, 18, 19, 22, 23, 24, 25, 26, 29 and March 1, 2, 3, 4, 7, 8, 9, 2016.**

**The following Critical Incident (CI) intakes were inspected concurrently with this RQI: 005128-16, 032380-15, 030514-15, 029710-15, 027324-15, 027246-15,**

**024480-15, 019362-15, 016477-15, 012083-15, 014687-15, 014217-15, 013001-15, 012751-15, 005650-15, 003449-15, 002031-15, 008932-14, 00517-14, 014372-15, 000080-15, 021146-15, 005122-16.**

**The following Complaint intakes were inspected concurrently with this RQI: 009202-14, 005342-14, 005138-14, 001807-16, 011961-15, 006121-16, 004173-16, 027136-15, 003465-15, 006379-14, 029944-15, 008438-15, 020690-15, 028798-15, 014350-15, 006050-16.**

**During the course of the inspection, the inspector(s) spoke with the Vice President of Operations (VPO), interim Administrator, the interim Director of Nursing and Personal Care (IDONPC), Assistant Directors of Nursing and Personal Care (ADONPC), Environmental Services Manager (ESM), Food Service Manager (FSM), Food Service Supervisor (FSS), Admissions Coordinator (AC), receptionist, registered nurses (RN), registered practical nurses (RPN), registered dietitian (RD), personal support workers (PSW), dietary aides (DA), activity aides (AA), staffing clerk, Residents' Council President, Residents' Council Vice President, Family Council Secretary, residents and family**

**members.**

**During the course of the inspections, the inspectors toured the home, observed resident care,**

**observed staff to resident interactions, observed meal service, reviewed resident health**

**records, meeting minutes, schedules, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**

**Critical Incident Response**

**Dignity, Choice and Privacy**

**Dining Observation**

**Falls Prevention**

**Family Council**

**Hospitalization and Change in Condition**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Sufficient Staffing**

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

- **12 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review of a Critical Incident submitted to the MOHLTC indicated that on a specified date in November 2015, an identified resident pushed another identified resident to the ground causing the second identified resident to sustain an injury. Interviews with two identified staff revealed that in November 2015, they witnessed the above mentioned incident.

Record review of the first identified resident's progress notes on a specified date in July 2015, revealed that he/she exhibited responsive behaviors towards staff in the dining room, and was seen by the Psychogeriatric Outreach team on specified dates in July and November 2015. Recommendations from the team in July 2015, included referring the resident to the Behavioural Support team, discuss with resident and family regarding an identified item in his/her room. Recommendations from the team in November 2015, included referring resident to the Behavioural Support team and an external resource, develop and sign a contract with resident that clearly indicates the negative consequences of not abiding by rules, discuss with resident and family regarding an identified item in the resident's room, and involving the resident's family member in the plan of care.

Interview with the identified RN and the interim Director of Nursing and Personal Care (IDONPC) confirmed that the home did not implement one of the interventions recommended by the Psychogeriatric Outreach team in July 2015; the home did not discuss with resident and family regarding the identified item in his/her room. The November 2015 interventions suggested by the Psychogeriatric team, such as involving the first identified resident's family member in plan of care, referring resident to an external resource, and getting the resident to sign a contract were also not implemented, even after the above mentioned altercation between the first and second identified resident occurred.

On a specified date in March 2016, in the dining room the inspector observed the first identified resident move towards another identified resident who was seated quietly at the table next to his/hers, shake his/her fists, and stated "shut up, shut up." Staff members in the area quickly intervened to prevent a potentially harmful interaction between the two residents.

The severity of the non-compliance and severity of harm was actual harm.

The scope of the non-compliance was isolated.

A review of the compliance history revealed the following non-compliance related to O.Reg. 79/10., s.54. (b). A VPC was previously issued for O.Reg. 79/10., s.54. (b) during a Resident Quality Inspection on October 9, 2014, under Inspection #2014_163109_0031. [s. 54. (b)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)The following order(s) have been amended:CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**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 :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #031's skin checklists revealed a written note by PSWs that on two specified dates in May 2015, the resident's limb was swollen, and it was check-marked on twelve identified dates in May 2015 that there was edema or swelling of the skin.

On a specified date in May 2015, registered staff documented that one of the resident's limbs was slightly swollen, warm to touch and tender. This was the first skin/wound note regarding this observation.

Interview with registered practical nurse (RPN) #157 confirmed that it was on the same specified date in May 2015, mentioned above, when she discovered the resident's swollen limb, documented in the progress notes and notified the doctor for further assessment. RPN #157 and the IDONPC indicated when PSWs notice skin problems the expectation is to report to registered nursing staff in order for them to complete a skin assessment, and confirmed that when resident #031 started showing signs of skin swelling it was not communicated between PSWs and registered nursing staff in a timely manner. [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

Record review of resident #008's flow sheet documentation  for oral care revealed that resident had refused twice daily oral care in January 2016 for 27 out of 31 days, and from February 1 to 24, 2016. Documentation in the resident's progress notes from Oct 2015- Feb 2016 indicated that the resident frequently refused care, and review of the resident's clinical record did not include a dental assessment.

Interviews with two identified PSWs revealed that resident was unable to do oral care independently and refused oral care when offered. Interview with an identified RN reported that it was not reported and he/she was not aware that the resident had been refusing oral care frequently, and did not assess the residents mouth or make a referral to the Social Worker for a dental assessment.

Interview with an ADONPC  revealed that the home's expectation is that the registered staff should have assessed the resident's mouth and followed up as required. ADONPC reported that a dental assessment was not offered to resident #008 and should have been. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Record review of a CI indicated that on a specified date in June 2015, an identified resident was found by a PSW at the beginning of the day shift, in bed half naked with dry feces on him/her, and feces all over the bedroom floor, on the bed and in the bathroom.

Record review of the home's investigation notes revealed that on the night shift before the specified date referred to above, in June 2015, the identified resident refused care offered by an identified PSW. The PSW attempted to check and change the resident's brief twice during the shift, and the last time was at approximately 0645 hours towards the end of the shift. The resident's incontinent product was not changed at all during the shift, an identified night shift registered staff denied being informed by the PSW, and the other couldn't remember if he/she was informed.

Interview with an identified PSW who worked on the night shift, revealed that he/she was not able to change the identified resident's incontinent product or assist him/her with toileting at all during the night shift on the above mentioned date in June 2015, as he/she refused care. The PSW reported that he/she did not document the resident's refusal of care.

Interview with an identified RPN revealed that he/she was informed by the day shift PSW that after receiving shift report the PSW went to the identified resident's room and discovered him/her half naked in bed with dried feces on him/her and feces all over the bedroom floor, on the bed and in the bathroom. The RPN reported that he/she proceeded to the resident's room, provided care to the resident and cleaned up the resident's room and bathroom with the identified PSW.

Interview with an ADONPC confirmed that staff on the night and day shift did not collaborate with each other regarding resident's refusal of care. [s. 6. (4) (b)]

4. The licensee has failed to ensure that that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of an identified resident's plan of care indicated a personal hygiene product was not to be used on the resident's skin.

An interview conducted with an identified PSW revealed that when providing personal care on the evening of February 4, 2015, he/she had not read the care

plan and used the identified product on the resident.

An interview conducted with the IDONPC confirmed that soap was not to be used on the resident's skin and the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A review of the progress notes for an identified resident revealed that on a specified date in June 2016, the Psychogeriatric outreach team from Humber River Hospital requested a Dementia Observation System (DOS) form be completed for the resident over the next five days, to identify pattern of his/her behaviour. Progress notes indicated that three days after the above mentioned date in June 2016, at a specified time, the identified resident was removed from in front of another identified resident, assessed for injury and noted to have sustained an injury. The progress note indicated the resident would be monitored to prevent further altercation.

A review of the first identified resident 's DOS form revealed that it was not completed on two specified dates in June 2015, from 0730 hours to 1500 hours and from 2330 hours to 0700 hours, and there was no documentation for two other specified dates in June 2015. The resident was transferred to another unit.

Review of the identified resident's progress notes and DOS form and interview with the IDONPC confirmed that the DOS form was not documented as ordered by the Psychogeriatric outreach team. [s. 6. (9)]

6. A review of resident #003's flow sheet documentation revealed no sign off for shower on a specified date in February 2016.
Interview with PSW #112 and RN #101 confirmed that a bed bath was given to the resident on the specified date in February 2016. PSW #112 reported that she forgot to document on the resident's flow sheet. [s. 6. (9) 1.]

7. 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 the resident's care needs changed or care set out in the plan was no longer necessary.

Record review of resident #003's care plan and kardex indicated that resident should be bathed twice weekly on specified days.

Interview with the resident revealed that his/her bathing days are on two other specified days of the week, different from those mentioned above. Interview with PSW #100 and RN #101 confirmed that resident #003's bathing days are the same as those specified days reported by the resident, and the care plan and kardex were not updated. [s. 6. (10) (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 to ensure that:***
***- the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,***
***- that the care set out in the plan of care is provided to the resident as specified in the plan,***
***-that the provision of the care set out in the plan of care is documented, and***
***- that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changes or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of the home's policy entitled Smoking Policy, Index I.D. HS J-40, revised date September 2, 2014, directs staff to stay with resident(s) who require supervision while smoking to ensure their safety. Record review of resident #044's smoking assessment dated May 25, 2015, indicated that the resident was not safe to smoke independently and required supervision.

Record review of a CI indicated that resident #044 eloped from the home on a specified date in August 2015 for approximately two and a half hours and was found at the mall by a staff member and returned to the home. Record review of the home's investigation notes indicated that an identified staff was supervising resident while he/she was smoking outside and was responsible to accompany the resident back safely into the home. Upon returning to the resident's unit with other residents' who required supervised smoking, resident #044 was discovered missing from the home.

Interview with activity aide (AA) #129 confirmed that resident #044 eloped from the home on a specified date in August 2015, as he/she did not ensure that the resident was accompanied back to his/her respective unit safely after supervised smoking in a designated area outside the home.

Interview with the IDONPC confirmed that the home's expectation is that activity staff who supervise residents while smoking are responsible for ensuring that the respective residents are accounted for, and escorted to and from their units. AA

#129 did not comply with the home's policy. [s. 8. (1)]

2. Record review of the home's policy entitled Pain Management, Index I.D. RCS G-60, dated July 15, 2013, revealed that upon initiation of a new pain management medication or an adjustment to dosage and/or frequency, a Pain Flow Sheet shall be initiated. Registered staff will evaluate the effectiveness of the medication on the Pain Flow sheet as well as in the resident's electronic progress notes. If pain is not relieved with initial interventions, notify physician for alternate pain control measures. A pain management assessment (UDA in PCC) is to be completed.

Record review of resident #031's progress notes revealed the resident started having pain on a specified date in May 2015, related to an injury. A new pain management medication four times a day was started three days later, and the dose was adjusted to three times a day five days later.

Interviews with RPN #157 and IDONPC confirmed that a pain flow sheet and pain assessment was  not completed for resident #031 according to the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. Record review of the home's policy entitled Medication Administration, Index I.D. RCS F-35 for Drug Destruction and Disposal, revised July 15, 2013, identifies all drugs that have expired are to be removed from the current medication system, including the medication cart, for destruction.

On February 25, 2016, the medication administration system was observed by the inspector. Contained in the bottom drawer of the medication cart the following medication was observed to be expired: one 500ml bottle of Aaromatic Cascara, expiration date January 2016.

On February 25, 2016, an interview with RPN #150 confirmed that the above mentioned medication was expired and it was removed from the cart. On the same date, a further inspection of government stock medications, located in the locked medication room, revealed the following expired medications:
- Aaromatic Cascara, two 500ml bottles, expiration dates January 2016,
- Sofax 100MG, 100 CAPS, two bottles, expiration dates May 2015,
- Calcium Carbonate 500mg, 120 caplets, expiration date March 2013,
- Dimenhydrinate 50mg, 10 suppositories, expiration date November 2015.

An interview with RN #136 confirmed the government stock medications mentioned

above, stored in the medication room were expired.

An interview with the IDONPC confirmed that the expired medications should have been removed from the medication cart and medication room. [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 to ensure that 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, is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observation of the lounge area located on the second floor in the responsive behaviour unit revealed this area to be in a bad state of repair. Cupboards were poorly painted with considerable damage to the cupboard surfaces. There was an open area where it appeared an appliance had been removed and had not been replaced, and trim was observed to be loose and coming off in various areas.

Review of the home's Cap Ex listing 2015 – 2017 did not include this area as one of the itemized, budgeted areas being considered for repair.

Interview with the interim Administrator confirmed that this area was not included on the home's Cap Ex 2015-2017 list and as such had not been identified as an area in need of repair. [s. 15. (2) (c)]

2. On February 17, 2016, between 0950 -1050 hours during the initial tour of the home, the inspector observed that the call bell in the third floor spa room was not working. When the inspector pulled the cord there was no audible sound heard.

The Environmental Services Manager (ESM) tested the bell and confirmed that this particular call bell was not working correctly. The IDONPC confirmed that the call bell in the spa room was not functioning. [s. 15. (2) (c)]

3. Record review of a CI report indicated that on a specified date in September 2015, an identified resident was incontinent of urine and called for assistance using the call bell in his/her room, which was not answered for hours.

Record review of the home's call bell activity report for the above mentioned specified date in September 2015 indicated that the resident 's call bell was not answered for periods of time throughout that day.

Interview with two identified PSWs revealed that the resident's call bell would often malfunction.

Interview with the interim DOC revealed that there were issues with the identified resident's call bell on the specified date in September 2015 mentioned above, and the home requested an assessment and repair from an external company two days later when they became aware of it. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs.

Record review of staffing schedules for February and March 2016 and interview with the staffing clerk #175 revealed that PSW staff were not replaced when scheduled staff called in sick on the weekends a total of 13 times on 2nd and 3rd floors.

Interviews with nine identified staff on the 1st, 2nd and 3rd floors revealed that they often worked short PSW staff on the weekends and would pick up the care for extra residents assigned to them. Staff revealed that they try their best to provide all care required when working short staffed as indicated in the residents plan of care, however sometimes resident care is compromised when they are unable to complete residents' baths or showers despite their efforts.

Interview with the interim Administrator shared that on a specified date in February 2016, staff worked one PSW short and an identified resident  did not receive a bath or shower and it was not documented.

Interview with the IDONPC revealed that she was not aware if the home had a written staffing plan and would find out. Interview with the interim Administrator revealed that the home did not have a written staffing plan available and would complete it as soon as possible. [s. 31. (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 to ensure that that there is a written staffing plan for the nursing and personal support services programs, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect was fully respected and promoted in a way that fully recognizes their individuality and respects their dignity.

On the evening of a specified date in February 2015, at a specified time, one identified PSW entered an identified resident's room located at the end of the hall, observed the resident was incontinent with a large amount of stool and began screaming. The scream, which could be heard some distance away at the nursing

station, was responded to by two other identified PSWs who ran to the room to provide assistance.

During interview on March 3, 2015, the first identified PSW confirmed that he/she went into the identified resident's room and said, "Oh my God!" when the incontinence was discovered.

Interview with one of the two other identified PSWs confirmed she heard the first identified PSW screaming from the resident's room.

Interview with the IDONPC confirmed that the resident was not treated with courtesy and respect by the first identified PSW in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted

Record review of an identified resident's care plan indicated that he/she requires two persons for total physical assistance with mechanical aid for transfers. Resident's care plan indicated that it is the resident's preference to be up prior to lunch at 1130-1200 hours, and back to bed at 1530-1600 hours. Resident wants room service for breakfast, and dinner as requested.

Interview with the identified resident revealed that he/she had previously requested to get up for lunch, then weeks ago requested to start getting up out of bed to have breakfast in the dining room. Subsequently staff did not provide him/her with transferring assistance in the morning to go to the dining room for breakfast. The resident reported that an identified staff explained that staff are busy providing care in the morning and two staff are not available at that time to transfer him out of bed for breakfast. The resident reported that he/she was transferred out of bed for breakfast only once in the past few weeks or longer, even though he/she has voiced his request to staff and an ADONPC.

Interviews with identified staff revealed that the resident had communicated his/her desire to get up for breakfast to them and also discussed it with management of the home himself. An identified RPN reported that it was discussed at a weekly unit team meeting in November 2015 with the charge nurse and other registered staff present. The resident's plan of care was not updated and staff were directed to

continue  getting the resident up for lunch.

Interview with an identified  ADONPC revealed that a meeting was held with the resident on a specified date in February 2016 and he/she will now be assisted out of bed  for breakfast in the mornings. Interview with the identified resident two days after the meeting confirmed that staff assisted him/her from bed for breakfast in the dining room and will continue to do so in the mornings now. [s. 3. (1) 4.]

3. The licensee has failed to ensure every resident's right to be told who was responsible for and who was providing the resident's direct care was fully respected and promoted.

Record review of a Critical Incident (CI) report  revealed an identified PSW was heard speaking inappropriately to an identified resident.

Record review of the home's investigation notes revealed that the identified PSW was heard screaming from the resident's room, located a distance from the nursing station. Interview notes revealed two other identified PSWs went to the resident 's room and did not introduce themselves prior to providing care to the resident.

An interview with one of the identified PSWs confirmed he/she heard the first identified PSW screaming from the resident's room at the nursing station and went to the resident's room immediately with the other identified PSW.

An interview with the IDONPC confirmed the above mentioned staff did not introduce themselves prior to providing care to the identified resident, and right of the resident to be told who was providing direct care was therefore not fully respected and promoted. [s. 3. (1) 7.]

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**WN #7:  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 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

Record review of an identified resident's plan of care did not identify the resident as high risk for falls or include any falls prevention interventions, consistent with a Falls Risk assessment on a specified date in Oct 2014 which identified the resident as high risk for falls.

Interview with RN #145 revealed that the identified resident's plan of care did not include any falls prevention interventions even though the resident was deemed high risk for falls. [s. 26. (3) 10.]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On February 25, 2016, in the dining room on an identified floor the inspector observed an identified staff feeding an identified resident with a spoon from a standing position. Interview with the staff confirmed that this was not the correct feeding position for residents who required feeding.

On February 26, 2016, in the same dining room mentioned above the inspector observed an identified RPN actively feeding two residents soup at table one from a standing position. Interview with the RPN confirmed she was standing, not sitting, and proper feeding technique position was not used.

Interviews with the IDONPC and Food Services Supervisor confirmed that proper feeding technique positions were not followed in the above mentioned instances. [s. 73. (1) 10.]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating in behaviour management.

Record review of the home's behaviour management training records for 2015 and interview with the interim DOC revealed that 17 out of 52 registered staff were not trained in 2015. [s. 76. (7) 3.]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for, cleaning of the home, including, (ii) supplies and devices, including personal assistance services devices.

Record review of the home's CI revealed that on a specified date in September 2015, an identified resident's son visited the resident and found his/her wheelchair cushion to be saturated with urine.

Interview with an identified RN revealed that on the specified date mentioned above, during the evening shift the resident's son complained about the resident's dirty wheelchair cushion and he/she rinsed the cushion cover and left it in the resident's washroom to dry. The RN reported that he/she was not aware that the home had a schedule to clean resident's wheelchairs and cushions on the convalescent unit.

Interview with the IDONPC revealed that the home did not have a wheelchair cleaning procedure and schedule in place on the convalescent unit, and will implement one as soon as possible. [s. 87. (2) (b)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**

**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**

**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**

**i. a breakdown or failure of the security system,**

**ii. a breakdown of major equipment or a system in the home,**

**iii. a loss of essential services, or**

**iv. flooding.**

**O. Reg. 79/10, s. 107 (3).**

**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director had been informed no later than one business day after the occurrence of the incident that caused an injury to a resident that resulted in the resident being taken to a hospital.

A review of an identified resident's clinical record revealed that when the resident was sent to hospital on a specified date in May 2015, was diagnosed with an injury. A new treatment for pain management four times a day was initiated for six days in May 2015, and then reduced to three times a day for six days in May 2015.

Interview with interim DOC indicated the home had not informed the Director no later than one business day after the occurrence of the incident that caused an injury because they did not deem the changes in the health status as significant. The IDONPC confirmed that because of the resident's treatment in the hospital and pain management treatment, the incident should have been reported to the Director within one business day. [s. 107. (3)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records**
**Every licensee of a long-term care home shall ensure that,**
**(a) a written record is created and maintained for each resident of the home; and**
**(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident’s written record was kept up to date at all times.

Record review of a CI and an identified resident 's progress notes reported that on a specified date in November 2015, the resident pushed another identified resident to the floor while they were both standing in front of the elevator. The second identified resident was transferred to hospital and sustained an injury.

Interview conducted with an identified RPN revealed that he/she witnessed the above mentioned incident and responded by immediately assessing the second identified resident for injuries, transferred the resident to hospital, notified the police, and commenced every  fifteen minutes monitoring of the first identified resident on the home's close monitoring form, however he/she did not document the commencement of close monitoring in the resident's progress notes. The identified RPN  reported the home's expectation is that after each resident to resident altercation close monitoring should be commenced for a minimum period of 72 hours. The resident's completed close monitoring form was not available.

Interview with the IDONPC confirmed the home's expectation is that after each resident to resident altercation close monitoring should be commenced, and that the home was unable to locate the first identified resident's completed close monitoring documentation. [s. 231. (a)]

**Issued on this 8 day of June 2016 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**
**Division des foyers de 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


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** BARBARA PARISOTTO (558) - (A1)

**Inspection No. / No de l'inspection :** 2016_382596_0004 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** 004698-16 (A1)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Jun 08, 2016;(A1)

**Licensee / Titulaire de permis :**
RYKKA CARE CENTRES LP
3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2

**LTC Home / Foyer de SLD :**
HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST, NORTH YORK, ON, M3N-1M9

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Linda Joseph-Massiah

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

(A1)
The licensee shall ensure that recommendations from the Psychogeriatric Outreach team will be implemented for resident #045 and any other resident exhibiting responsive behaviours that has been assessed by the Psychogeriatric Outreach team, to minimize the risk of altercations and potentially harmful interactions between residents.

**Grounds / Motifs :**

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review of a Critical Incident (CI) report submitted to the MOHLTC indicated that on a specified date in November 2015, an identified resident pushed another identified resident to the ground, causing the second identified resident to sustain an injury. Interviews with two identified staff revealed that in November 2015, they

witnessed the above mentioned incident.

Record review of the first identified resident's progress notes on a specified date in July 2015, revealed that the resident exhibited responsive behaviors towards staff in the dining room, and was seen by the Psychogeriatric Outreach team on specified dates in July and November 2015. Recommendations from the team in July 2015, included referring resident to the Behavioural Support team, discuss with resident and family regarding an identified item in his/her room. Recommendations from the team in November 2015, included referring resident to the Behavioural Support team and an external resource, develop and sign a contract with resident that clearly indicates the negative consequences of not abiding by rules, discuss with resident and family regarding the identified item in his/her room, and involving the resident's family member in the  plan of care.

Interview with an identified RN and the interim Director of Nursing and Personal Care (IDONPC) confirmed that the home did not implement one of the interventions recommended by the Psychogeriatric Outreach team in July 2015; the home did not discuss with resident and family regarding the identified item in his/her room. The November 2015 interventions suggested by the Psychogeriatric team, such as involving the first identified resident's family member in plan of care, referring resident to an external resource, and getting the resident to sign a contract were also not implemented, even after the above mentioned altercation between the first and second identified resident occurred.

On a specified date in March 2016, in the dining room the inspector observed the first identified resident move towards another identified resident who was seated quietly at the table next to his/hers, shake his/her fists, and stated  "shut up, shut up." Staff members in the area quickly intervened to prevent a potentially harmful interaction between the two residents.

The severity of the non-compliance and severity of harm was actual harm.

The scope of the non-compliance was isolated.

A review of the compliance history revealed the following non-compliance related to O.Reg. 79/10., s.54. (b). A VPC was previously issued for O.Reg. 79/10., s.54. (b) during a Resident Quality Inspection on October 9, 2014, under Inspection #2014_163109_0031. (596)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :**

Jun 10, 2016(A1)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 8 day of June 2016 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** BARBARA PARISOTTO - (A1)

**Service Area Office /**
**Bureau régional de services :** Toronto