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 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 11, 2017 | 2017_653648_0007 | 033280-16, 000243-17 | 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

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

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

JOVAIRIA AWAN (648)

## 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): April 19, 20, May 9, 10, 11, 12, 15, 16, 17, 18, 19, 24, 25, 26, 29, and 30, 2017.**

**The following intakes were inspected:**
**Complaint Log #033280-16 related to housekeeping, laundry service, continence care and bowel management, plan of care, and duty to protect.**
**Complaint Log #000243-17 related to nutrition care and hydration programs and plan of care,**
**Critical Incident System Log # 000448-17 related to plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), interim Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), and residents.**

**During the course of this inspection, the inspector reviewed resident clinical records, staff schedules, and made observations of the home and staff.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Laundry**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

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

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

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) info line received a complaint on an identified date, with concerns related to how resident #011 received continence care.

Review of resident #011's clinical records identified a deterioration in residents status following hospitalization on an identified date and treatment for identified medical diagnoses. The clinical records further identified that resident #011 changed from limited to extensive assistance for activities of daily living (ADL), to extensive to total dependence for ADL care. The clinical records identified resident #011 had a decline in continence care requiring a continence product and provision of continence care in a specified manner.
Review of resident #011's written plan of care currently active at the time of the inspection identified he/she was incontinent of bowel and bladder, and required extensive assistance with two staff with the provision of care in an identified manner. The written plan of care identified resident #011 required an identified product and continence care in a specified manner.

Interview with PSW #115 identified resident #011 was an extensive two person assist for transferring. PSW #115 reported he/she had been providing continence care in an identified manner with two staff assistance for the past month up until the time of the inspection. Review of resident #011's kardex with PSW #115 identified that resident #011's written plan of care directed staff to provide continence care in a specified

manner. PSW #115 reported that resident #011 had expressed preference for provision of continence care in a manner not directed by the plan of care and that he/she provided continence care in this manner. PSW #115 identified the current manner in which continence care was provided was inconsistent with that which was outlined in the the written plan of care.

Review of resident #011's written plan of care with RN #155 identified resident was to be provided continence care in an identified manner as indicated in the care plan interventions. RN #155 acknowledged PSW staff and had not communicated that resident #011 had been provided care in a manner of his/her preference from that which was outlined in the written plan of care, to the registered staff prior to the inspection. RN #155 acknowledged that the staff did not follow the plan of care as specified.

Interviews conducted with interim ADOC's #106 and #156 identified staff in the home were expected to provide the care set out in the plan of care to the resident.ADOC's #106 and #156 acknowledged resident #011's had not been provided continence care as specified in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the residents care needs change or care set out in the plan is no longer necessary.

The MOHLTC info line received a complaint on an identified date, with concerns related to how resident #011 received continence care.

Review of resident #011's written plan of care currently active at the time of the inspection identified he/she required extensive assistance with two staff with the provision of continence care in an identified manner. The written plan of care identified resident #011 required an identified product and continence care in a specified manner.

Interview with PSW #115 identified resident #011 was an extensive two person assist for transferring. PSW #115 reported that he/she had been assisting resident #011 in an identified manner for the past month up until this inspection. PSW #115 reported resident #011 had expressed preference for provision of continence care in the identified manner as provided. Review of resident #011's kardex with PSW #115 identified that the resident's written plan of care, directed staff to provide continence care in an identified manner which differed from the current manner in which continence care was being provided to the resident. PSW#115 reported he/she did not report that he/she had been

consistently providing continence care in a manner which differed from that which had been specified in the written plan of care.

Interview with RN#117 stated PSW staff are expected to report changes in a residents care needs to registered staff, including changes in the provision of care so that a resident can be assessed and the plan of care may be updated accordingly. RN #117 acknowledged that PSW staff had provided resident #011 continence care in a manner which was not identified in the written plan of care and had not made registered staff aware of this, which would have prompted an assessment of the resident's continence care needs and revision of the plan of care.

RN #155 acknowledged PSW staff had not communicated the manner in which they provided continence care for resident #011 to the registered staff prior to the inspection.

Interviews with RPN #151, RN#155, and RN #117 identified resident #011 required extensive assistance for care. Review of resident #011's written plan of care, with RPN #151, RN #155, and RN #117 directed that resident #011 was to be provided continence care in an identified manner. RPN #151 and RN #155 acknowledged PSW staff had not communicated the change in the manner in which resident #011's received continence care.

Interviews with interim ADOC's #106 and #156 identified staff were expected to report any changes in a residents care needs to registered staff in order to follow up with appropriate assessments for the resident. ADOC #106 and ADOC #156 was unable to demonstrate if resident #011 had been reassessed so that the care plan could be reviewed and revised to reflect the current assessed needs of the resident. [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 care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff use safe transferring techniques when assisting residents.

The home submitted a CIS report to the MOHLTC on an identified date, identifying an injury to resident #011 for which the resident was taken to hospital. The CIS report indicated that resident #011 was found with a change in skin integrity.

Review of resident #011's written plan of care identified he/she required extensive staff assistance for care. Resident #011's care plan further identified that he/she required two staff for total transfer assistance.

Review of resident #011's progress notes identified that on an identified date, that a PSW had reported resident #011 had a skin impairment of unknown cause to an area of the residents body to RPN #151. The MD was notified, and resident #011 was transferred to hospital upon being assessed by RPN #116. Subsequent progress notes dated on an identified date, documented by RPN #151 on an identified shift from the day of the incident, identified resident #011's skin imparity.

Interview with resident #011's SDM revealed resident was not independent in mobility.

PSW #157 and #162 were identified to be working on an identified shift in resident #011's home area during the time of the incident. Interview with PSW #157 revealed resident #011 required extensive assistance with two person transfers. PSW #157 and #162 confirmed they did not offer assistance to PSW #190 to transfer resident #011 on the date of the incident, during an identified shift to PSW #190.

RPN #151 was identified to be on an identified in resident #011's home area at the time of the incident. Interview with RPN #151 identified resident #011 required a two person assisted transfer to ensure he/she was safely transferred.

Interview with PSW #190 indicated he/she was aware resident #011 required a two person transfer. PSW #190 identified that he/she had transferred resident #011 independently on the date of the incident, without the assistance of another staff member following the evening meal. PSW #190 reported he/she removed clothing from resident #011 following the transfer. Upon removing the clothing, PSW #190 identified skin imparity on resident #011's body which he/she immediately reported to RN# 117.

The homes investigation identified that PSW #190 discovered resident #011's skin imparity upon removing clothing after transferring him/her during an identified on the date of the incident. The homes investigation revealed PSW #158 stated resident #011's skin was without any visible injury or altered integrity during the previous shift on the date of the incident. Review of the homes investigation related to the CIS report revealed PSW #190 reported to the homes third party investigator that he/she transferred resident #011 independently, contrary to the two staff transfer required for resident #011. The homes investigation concluded PSW #190 did not follow the written plan of care for resident #011 due to the independent transfer of the resident.

Interview with ADOC #156 identified two person assistance for transfers was instituted for resident #011 to ensure his/her safety. ADOC #156 reported PSW #190 disclosed that he/she transferred resident #011 independently on the date of the incident, and demonstrated to the ADOC #156 how he/she had independently transferred resident #011 during the homes investigation. The ADOC #156 confirmed resident #011 was not safely transferred at the time of the incident by PSW #190. Interviews with the administrator and the ADOC confirmed that the home did not determine the cause of the injury to resident #011. [s. 36.]

***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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

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

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The license failed to ensure that the homes nutrition care and hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The MOHLTC info line received a complaint on an identified date, indicating resident #011 had significant weight loss since admission. Interview with the complainant reiterated the concern related to resident #011's nutritional status including weight loss, and indicated staff did not spend adequate time to feed resident #011.

Review of resident #011 clinical records identified he/she was admitted to the home on an identified date and was weighed the following day to be an identified weight. Review of resident #011's weight over a period of 10 months prior to this inspection reflected a significant weight loss. Resident #011's weight history was further reviewed for the ten month period prior to this period, and reflected a further significant weight loss.

During the course of the inspection, resident #011 was observed during multiple meal times. Observations identified that resident #011 received fluid beverages, an identified

diet, and an oral nutrition supplement at an identified meal time. These observations identified resident accepted 25 - 75% of the total food and fluids (including the oral nutrition supplement) offered with assisted feeding from staff.

Resident #011's written plan of care identified he/she was at an identified nutrition risk related to varying intake requiring an oral nutrition supplement for weight maintenance and significant weight loss. Interventions in the written plan of care included resident #011 was to be offered an oral nutrition supplement at identified times, and that resident #011 was to receive mechanically altered diet with fluids.

Review of resident #011's point of care (POC) and electronic medical administration records did not identify whether the oral nutrition supplement had been offered and how much had been accepted by resident #011 at the identified times it was to be offered to the resident.

Interview with PSW #115 identified resident was to receive the oral nutrition supplement as part of his/her nutrition care. PSW#115 confirmed PSW staff were not able to document when resident #011 took the supplement or the quantity accepted in POC. PSW #115 was unable to demonstrate how intake of oral nutrition supplements such would be monitored and evaluated for resident #011.

Interviews with PSW's #157 and #158 confirmed PSW were not able to document and monitor intake of resident #011's oral nutrition supplement.

Interview with RPN #151 revealed resident intake of food and fluids was to be recorded by PSW staff and documented in POC for monitoring and evaluation. RPN #151 identified oral nutrition supplements prescribed to residents would not be recorded. RPN#151 was unable to demonstrate how intake of oral nutrition supplements would be monitored and evaluated.

Interview with the RD indicated residents which required additional nutrition for weight loss are offered oral supplements. The RD identified the evaluation of a nutrition interventions' efficacy included monitoring a resident's acceptance of oral nutritional supplements if they have been prescribed. The RD confirmed the home did not currently monitor the intake of oral nutritional supplements and that a system to assess and evaluate the acceptance of oral nutrition supplements by residents was not available. The RD demonstrated awareness of the legislative requirement requiring monitoring and evaluation of food and fluid intake under nutrition services of a long term care home. The

RD confirmed that the current process in the home for monitoring and evaluating food and fluid intake did not meet the legislative requirement. The RD identified resident #011 to be at high nutrition risk and reviewed resident #011's oral nutrition supplement intervention. The RD acknowledged he/she would not be able to monitor or evaluate resident #011's intake of the prescribed oral supplement.

Interview with interim ADOC #156 confirmed the home did not monitor and evaluate the acceptance and intake of oral nutrition supplements prescribed to residents.

The home failed to ensure there was a system to monitor and evaluate the food and fluid intake of residents with identified risks to nutrition and hydration. [s. 68. (2) (d)]

***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 the homes programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.***

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**Issued on this 18th day of August, 2017**

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

**Original report signed by the inspector.**