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 4, 2017	2017_595604_0011	019304-16, 022481-16, 024013-16, 026596-16, 028294-16, 028742-16, 029552-16, 030321-16, 030680-16, 031144-16, 034315-16, 034769-16, 035174-16, 004146-17, 004399-17, 004725-17, 004973-17, 005252-17, 007070-17, 009134-17	Critical Incident System

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

SHIHANA RUMZI (604), JENNIFER BROWN (647), JOY IERACI (665), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 19, 20, 21, 24, 25, 26, 27, and, 28, May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 29, and 30, 2017.

The following intakes were inspected:
Resident to resident abuse logs #019304-16, 035174-16, and 004146-17,

Staff to resident abuse logs #022481-16, 026596-16, and 005252-17,

Missing resident logs #024013-16, and 009134-17,

Injury requiring transfer to hospital log #028294-16,

Falls logs #028742-16, 029552-16, and 030680-16,

Financial abuse log #030321-16,

Injury of unknown origin logs #031144-16, and 000448-17,

Environmental log #034769-16,

Care not provided log #004399-17,

Responsive behaviour log #004725-17,

Elopement log #004973-17,

Medication error log #007070-17.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Interim Director of Care (IDOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), RAI-Coordinator (RC), Falls Prevention Lead (FPL), Skin and Wound Care Lead (SWL), Social Worker (SW), Quality Care Coordinator (QCC), Financial Clerk (FL), Housekeeping Aide (HA), Responsive Behaviour Lead (RBL), Nursing Administrative Assistant (NAA), Registered Dietitian (RD), Receptionist, Dietary Manager (DM),

Physiotherapy Assistant (PT), Residents, Substitute Decision Makers (SDMs), and residents.

During the course of the inspection, the inspectors made observations of staff and resident interactions, provision of care, conducted reviews of health records, home's Client Service Response (CSR) forms for complaints, home's Critical Incident System (CIS) reports , staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), Director, indicating there had been a medication error which resulted in an adverse drug reaction involving resident #061.

Record review of the CIS report and the clinical records indicated that resident #061 was admitted to the home on an identified date. A review of the admission medication orders indicated the resident had an order for an identified medication for his/her identified diagnosis.
A review of the Electronic Medication Administration Record (EMARS) for an identified date, indicated that the admitting registered staff member transcribed an identified physician order. A further review of the EMARS for another identified date, indicated that resident #061 was administered eight doses of an identified medication 11 times in error on four identified dates.

An interview with the Associate Director of Care (ADOC) #106 indicated that all medication orders are to be checked by two registered staff members. The ADOC further indicated the first registered staff member is to transcribe the orders from the admission paperwork and the second registered staff member is required to cross reference what the registered staff member transcribed. The ADOC acknowledged that the new admission order form for an identified date, had not been checked by a second registered staff member to ensure the accuracy of the transcription.

An interview with the DOC acknowledged that resident #061 had not received the identified medication in accordance with the directions for use specified by the prescriber and therefore had to be transferred to the hospital on an identified date, with a decline in health status.

2. The home submitted a CIS report on an identified date to the MOHLTC Director, indicating a medication error had occurred resulting in an adverse drug reaction which involved resident #043.

Record review of the CIS and the clinical records indicated resident #043 resided in an identified care unit and had returned from hospital with an identified diagnosis on an identified date. The resident returned to the home with a physician's order with an identified medication which was to be administered daily for five days. The CIS report further indicated that the medication was not entered into EMAR and the nurse on duty at the time of the resident's readmission administered the first dose of the identified

medication. The CIS report indicated the following eight doses of the identified medication had not been administered to the resident and his/her health declined and was readmitted to hospital on an identified date with an identified diagnosis.

Interviews with Registered Nurse (RN) #137 and Registered Practical Nurse (RPN) #138 both indicated resident #043 had returned to the home on an identified date, from the hospital with a new medication order which was to be administered daily for five days at change of shift. The registered staff indicated that they had faxed the new medication order to the pharmacy and confirmed that they did not enter the medication or dosage into EMAR as required. RN #137 indicated he/she administered one dose of the identified medication to the resident from the home's emergency supply until the remaining doses were received from the pharmacy.

During an interview with RPN #138, he/she indicated he/she was on vacation and upon his/her return he/she reviewed the medication delivery records from Pharmacy. The RPN indicated he/she could not locate any confirmation that resident #043's prescribed medication had been received. The RPN stated he/she contacted the pharmacy and confirmed that they had not received the original order of the medication and therefore, had not sent it to the home. The RPN confirmed that the resident had only received one dose of the medication and had not received the prescribed eight doses as prescribed by the physician.

An interview with the Director of Care (DOC) acknowledged that resident #043 had not received the identified medication in accordance with the directions for use as specified by the prescriber and therefore had to be transferred back to the hospital, for further assessment and was diagnosed with an identified diagnosis.

The home is being served an order as two identified residents had not been administered their medications in accordance with the directions for use as specified by the prescriber, resulting in a change in health status. Resident #061 was administered 11 doses of an identified medication four times daily in error for four days. Resident #043 returned from hospital on an identified date with an identified medication order which was to be administered twice daily for five days. The resident received the initial dose and the remaining eight doses had not been administered. The resident's health declined and was sent to hospital for further assessment on an identified date.

The severity of the non-compliance and the severity of harm and risk where actual as resident #061 and #043 were not administered their medication as prescribed.

The scope of the non-compliance was pattern.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 131 (2), was issued. The Non-compliances are as follows:
-Inspection #2013-162109-0045, Complaint Inspection – WN

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The home submitted a CIS report on an identified date to the MOHLTC Director indicating that at resident #044 had been seen going to an identified location of the home and at an identified time, the resident was no longer there.

A clinical record review revealed the home received a phone call from the police reporting that they had found resident #044 at an identified location outside the home. The police returned resident #044 to the home within three hours of him/her being identified as being missing and sustained no injuries.

A review of the plan of care indicated resident #044 had an identified safety device at all times as he/she was at risk for identified behaviours. Observation of resident #044 conducted during the inspection confirmed that resident #044 had the identified safety device.

An interview with RN #118 and RPN #139 both acknowledged resident #044 had identified behaviours. RN #118 and RPN #139 indicated that if someone had called for the elevator it would have transferred resident #044 to the main floor where resident #044 would be able to exit the building. RN #118 and RPN #139 acknowledged that resident #044 had an identified safety equipment and confirmed that it does not work on the home area should resident leave. Both RN #118 and RPN #139 indicated that should the resident approach an identified area of the home, the alarm would sound and be audible at the reception area and not on the originating home area.

Observation conducted on an identified floor for resident #044 revealed that there had been a coded key pad to enter the elevator and a coded key pad to change floors.

An interview with Receptionist #134 indicated that he/she leaves the home at an identified time, and there is no one at reception after he/she leaves to greet visitors or observe residents. The receptionist further indicated that resident #044 would have been able to leave the building when a visitor entered or exited the home because there would have been no one to observe the resident or to hear the alarm sound.

An interview with the Administrator indicated resident #044 was at risk for elopement. The Administrator acknowledged during the interview that there had been no safety measures put into place after the receptionist leaves. The Administrator further acknowledged that the home had not provided resident #044 with a safe and secure environment.

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 ensure that the home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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. (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. (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 staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The home submitted a CIS report on an identified to the MOHLTC, Director. The CIS indicated resident #006 had an incident in an identified location of the home. The resident sustained identified injuries and was transferred to hospital on and returned to the LTC home on an identified date, with an identified diagnosis.

Record review of resident #006's identified assessment tool, and plan of care revealed resident #006 was at risk for falls. The falls assessment tool was completed on two identified dates, identified resident #006's falls risk as a level two indicating moderate fall risk.

During an identified period resident #006 had sustained multiple falls.

Record review revealed Physiotherapist (PT) #153 completed a post fall assessment on an identified date, after resident #006 had sustained several falls within an identified period of time. The PT recommended the resident use two identified equipment in order to reduce injuries from a fall.

A review of resident #006's written plan of care with for an identified period of time did not include the use of identified equipment as recommended by the PT. Record review did not reveal documentation that the use of equipment was addressed by the home.

Multiple observations conducted for resident #006 by the inspector revealed resident did not have the identified equipment recommended by PT.

An interview with PT #153 stated it is the home's process to communicate his/her recommendations regarding residents assessments to the nurse on the unit and document his/her recommendations in a progress note and the nurse would communicate the recommendations to the PSWs and the written plan of care will be updated by the registered staff. The PT indicated he/she made recommendations for resident #006 to use two identified pieces of equipment to reduce the injuries from falls. The PT stated he/she communicated the recommendations to the unit nurse but was unable to recall the name of the nurse and documented in the post fall assessment for the resident. The PT acknowledged resident #006's written plan of care did not contain the use of one of the identified pieces of equipment as an intervention.

Interviews with PSW #104 and RN #105 acknowledged resident #006 did not have the identified piece of equipment for fall prevention and the staff indicated they were unaware the resident was to have the identified equipment as a fall intervention.

An interview with RN #125 indicated it is the home's process for PT to document fall prevention recommendations in a progress note and communicate the recommendations to the registered staff on the unit. The registered staff communicates the recommendations to the rest of the unit staff and updates the plan of care.

AN interview with ADOC/Fall Prevention Lead #106 indicated it is the home's expectation for the registered staff to implement PT recommendations and update the plan of care. The ADOC reviewed PT #153's recommendations for resident #006 and acknowledged the home did not address nor implemented the use of an identified pieces of equipment for the resident.

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating on an identified date and shift, PSW #101 observed resident #062 was being inappropriate with resident #063 in an identified area of the home. The incident was first reported to MOHLTC on an identified date, through the after-hours MOHLTC line.

Review of resident #062's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and written plan of care indicated the resident had physical impairment and was independent related to skills for daily decision-making.

Review of the resident #062's written plan of care and progress notes carried out on an identified date, revealed the resident was to be monitored for during an identified duration of time for his/her identified responsive behaviours. One of the recommendations made by Behaviour Services Coordinator (BSC) #159, was to continue the observation as identified above. Further review of the resident's written plan of care indicated on an identified date, observations for the resident's identified responsive behaviours were revised to a longer duration of observation during the day. A review of the progress notes and assessment records revealed no evidence of the changes of the duration for monitoring the resident.

An interview with BSC #159 indicated resident #062 was to be observed at set duration and was placed on one-on-one care after the above mentioned incident. Due to the change in the resident's behaviour, a collaborative decision between the BSC and nursing was made to discontinue the one-on-one care and an identified duration of time for observation to commence. The observation duration changed at that time and on an identified date BSC reassessed the resident's mood and behaviours and recommended to continue with the set duration for observations. The BSC indicated it was nursing's decision to revise the written plan of care to a longer duration for observation occurred on an identified date, and he/she was not involved at that time.

Interviews conducted with RPN #168, #171, and Resident Assessment Instrument Coordinator (RC) #170 indicated that on an identified date, an interdisciplinary care plan review took place. RPN #168 and the RC did not recall why the observations were

revised. RPN #171 indicated he/she recalls he/she was told by the PSW's that the resident's behaviour had changed and the resident stayed more often in an identified area, and therefore the resident can be monitored during an identified time period. The staff members did not recall a collaboration between the BSC and nursing had occurred for revising the resident's observation.

An interview with ADOC #156 indicated nursing should collaborate with the BSC in the development of the resident's written plan of care for his/her identified inappropriate responsive behaviours. The ADOC confirmed on an identified date, the BSC recommended to continue the observation for an identified time period for resident #062, and nursing staff should consult the BSC before revising the observation duration. The ADOC further confirmed that since the BSC was not consulted, no collaboration had occurred between nursing and the BSC for the development of the resident's observation plan of care.

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

The home submitted a CIS report on an identified date to the MOHLTC, Director. The CIS report indicated resident #006 had a fall and was found in an identified location of the home on the floor. The resident sustained injuries and was transferred to hospital on an identified date, and returned to the LTC home on with an identified diagnosis.

Record review revealed resident #006 had a predisposing diagnosis and the resident was receiving two identified medications related to the predisposing diagnosis and was to receive the medication three times a day. On an identified date, the RD assessed the resident and made PRN recommended when the residents meal intake was low.

A review of resident #006's physician's orders revealed the physician authorized the recommendation from the RD, on an identified date, once the resident returned from hospital.

Review of the written plan of care with a last reviewed on an identified date, and the current plan of care directed registered staff to provide RD recommendation if resident #006's meal intake was low to prevent identified diagnosis.

Review of resident #006's percentage of food consumed at meals revealed the resident had low intake and the RD recommendations where not carried out for 213 occasion with

an identified period of time.

Review of resident #006's EMARS for an identified period of time in 2016, and 2017, revealed plan of care interventions from the RD was not followed.

An interview with Registered Practical Nurse (RPN) #196 indicated it is the home's expectation for registered staff to follow the plan of care of residents. The RPN reviewed the current written plan of care for resident #006 and indicated the PRN order made by the RD was in the written plan of care. The RPN reviewed the PSW's flow sheet for a duration of time in 2017, of percentage of food consumed at meals and the EMAR record, for corresponding dates as indicated and confirmed the resident had low meal intake. The RPN indicated during this identified time period, when resident #006 had low meal intake the RD recommondations were not carried out and acknowledged registered staff did not follow home's expectation in following the plan of care for resident #006.

An interview with RN #105 indicated it is the home's expectation for staff to follow the plan of care of the residents. The RN revealed he/she was not aware of resident #006's PRN order made by the RD until he/she reviewed the EMAR for the resident and acknowledged he/she did not follow home's expectation regarding following the plan of care for resident #006.

Interviews with DOC #107 and ADOC #106 indicated it is the home's expectation for the plan of care for residents be followed by the home staff. The DOC and ADOC reviewed resident #006's plans of care and EMAR records for an identified duration of time in 2016, and 2017, and the PSW flow sheets on the percentage of food consumed at meals. The DOC and ADOC acknowledged resident #006 had a PRN RD recommendation order which is to be administered if the resident intake was low and stated that the residents intakes for the dates indicated showed the resident had low meal intake and the nursing staff did not administered the PRN order and stated the home did not follow the plan of care for resident #006.

4. 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.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating unlawful conduct had occurred which resulted in harm/risk of harm to a resident. The CIS further indicated resident #041 had struck resident #050.

The admission documentation indicated resident #041 had been admitted with cognitive impairment. Resident #041 had been assessed prior to the above mentioned incident utilizing the "Responsive Behaviour Risk Screening" tool and had been categorized as minimal to no risk for responsive behaviours.

A review of a psychiatry consult note indicated resident #041 had a significant cognitive decline, cooperative however and is disoriented to his/her whereabouts. A review of a psychiatry consult which had been one day prior to the above mentioned incident indicated that resident #041 had identified responsive behaviours.

A review of the written care plan indicated resident #041 was required to be monitored during an identified period of time by staff to observe the residents behaviours.

Interviews conducted with PSW #102, RPN #114, and RN #118, acknowledged that the written care plan had indicated that resident #041 was to be monitored during an identified period of time by staff to observe his/her behaviour. The above mentioned staff further indicated that resident #041 was no longer being monitored as indicated in the plan of care as resident #041 had not shown any further responsive behaviours.

An interview with the Responsive Behaviour Lead (RBL) #159 indicated that resident #041 had no longer been required to be monitored for the identified duration of time for responsive behaviour as the written plan of care indicated.

An interview with the ADOC #156 indicated that the plan of care for resident #041 had not been reviewed or revised when the resident's care needs changed.

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 ensure that;
-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
-staff and others involved in the different aspects of care of the resident collaborate with each other 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,
-care set out in the plan of care is provided to the resident as specified in the plan,
-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 change, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system, was complied with.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating that on an identified date resident #007 was found in an identified location of

the home to have fallen and was transferred to hospital the next day for further assessment. The resident was diagnosed with an identified diagnosis and returned to the LTC home on an identified date.

A review of the home's "Falls Prevention Program" with a revised date of March 2014, indicated, under the "Fall Risk Assessment" policy, and procedure number four directed staff to complete the "Fall Risk Assessment" when there is a functional change in status and does not trigger a RAI MDS significant change in status, to identify potential risks and to determine interventions to be implemented by the interdisciplinary team. The "Falls Prevention Program" further indicated under the Roles of the Interdisciplinary Team, the program directs the Falls Prevention Coordinator to ensure that a fall risk assessment is completed after a new fall that has not triggered a significant change in status.

A review of the PCC notes indicated prior to resident #007 first incident, resident utilized an identified mobility device for ambulation and upon resident #007's return from hospital and the resident had significant injury. Resident #007 was provided an ambulation device by PT #153 as the resident's functional status changed after.

From a review of the Falls Assessment Tool in the Assessment Tab on PCC the inspector was unable to locate a Falls Assessment Tool being carried out for resident's returned from hospital.

An interview with RPN #180 indicated it is the home's expectation for the Falls Assessment to be completed when a resident returns from hospital post fall. The RPN reviewed resident #007's electronic documentation and was not able to find a Falls Assessment upon resident's return from hospital.

An interview with ADOC and Falls Prevention Lead (FPL) #106 indicated it is the home's expectation when a resident is sent out to hospital related to a fall and then returns from hospital a Falls Assessment is to be completed. The ADOC reviewed the electronic documentation for resident #007 and confirmed he/she was not able to find a Falls Assessment upon resident #007's return from hospital, after a change in the residents functional status. The ADOC further stated the home's process in the completion of the Falls Assessment upon resident #007's return from hospital was not followed.

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 ensure that any plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a CIS report on an identified date to the MOHLTC Director indicating resident to resident abuse involving resident #062 and #063 which had occurred on an identified date. The CIS stated on an identified shift PSW #101 observed resident #062 being inappropriate towards resident #063 in an identified location of the home. The incident was first reported to MOHLTC on an identified date, through the after-hours MOHLTC line.

A review of resident #062's RAI-MDS assessment and plan of care indicated the resident had physical impairment and was independent with cognitive skills for daily decision-making.

A review of resident #063's RAI-MDS assessment and plan of care indicated the resident was physical and cognitive impaired.

A review of the progress notes for resident #062 and the incident reports indicated during an identified time and shift PSW #101 observed resident #062 being inappropriate towards resident #063. Both residents were sitting in an identified location of the home.

PSW #101 immediately told resident #062 to stop and then separated the residents. Resident #063 was assessed by RPN #132 and found no injuries.

An interview with resident #062 indicated he/she was aware resident #063 was incapable of giving consent. The resident confirmed he/she recalled the above mentioned incident and confirmed he/she was inappropriate with resident #062.

An interview with PSW #101 indicated on an identified date and shift, he/she observed resident #062 and observed resident #062 being inappropriate with resident #063.

Interviews conducted with PSW #101 and RPN #132 indicated resident #063 did not demonstrate any distress or sustained any injuries after the incident. The staff members confirmed resident #063 was incapable to provide consent and considered the incident to be abuse towards the resident by resident #062.

An interview with ADOC #156 and the Administrator confirmed the above incident had occurred and the home had failed to protect resident #063 from abuse from resident #062.

During further reviews of resident #062's progress note for an identified date it indicated during an identified meal service, RPN #132 observed resident #062 talking to resident #064 inappropriately. Resident #062 was informed that this behaviour was inappropriate. The above incident was not included in the CIS report which was submitted to the MOHLTC on an identified date, or through the after-hours MOHLTC line.

A review of resident #064's RAI-MDS assessment and plan of care indicated the resident was cognitively and physically impaired.

An interview with resident #064 indicated he/she could not recall the incident above.

An interview with RPN #132 indicated on an identified shift and meal service, that resident #062 exhibited an identified responsive behaviour toward to resident #064 in an identified location of the home and resident #064 was upset. The RPN stated he/she told resident #062 to stop and indicated it was inappropriate behaviour, and the resident stopped. The RPN indicated he/she considered the incident as abuse towards resident #064, and he/she recorded and reported the incident to RN #118.

An interview with RN #118 indicated he/she had no recollection of the incident above.

An interview with ADOC #156 indicated he/she became aware of the incident after he/she returned from holidays. The ADOC also confirmed the above mentioned incident had occurred and that the home had failed to protect resident #064 from abuse from resident #062.

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 ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated.

The home submitted a CIS report on an identified date to the MOHLTC Director indicating the morning of an identified date, PSW #101 observed resident #062 to be inappropriate with resident #063 in an identified location of the home. The incident was first reported to MOHLTC on an identified date, through the after-hours MOHLTC line.

A review of resident #062's RAI-MDS assessment and plan of care indicated the resident had physical impairment and was independent with cognitive skills for daily decision-making.

During further reviews of resident #062's progress notes indicated during an identified meal service, RPN #132 observed resident #062 talking to resident #064 inappropriately. Resident #062 was informed that this behaviour was inappropriate. The above incident was not included in the CIS report submitted on an identified date to the MOHLT Director or through the after-hours MOHLTC line.

Further review of the home's "Risk Management Incident" and progress notes revealed no records for the incident above.

Review of resident #064's RAI-MDS assessment and plan of care indicated the resident was cognitively and physically impaired.

Interview with resident #064 indicated he/she had no recollection of the incident.

An interview with RPN #132 indicated on an identified date and meal service, resident #062 exhibited an identified responsive behaviour towards resident #064 in an identified area of the home. The RPN indicated he/she considered the incident as abuse towards resident #064, and recorded and reported the incident to RN #118. The RPN indicated he/she was unaware if the home had conducted an investigation into the incident.

An interview with ADOC #156 indicated he/she became aware of the above incident after he/she returned from holidays. The ADOC stated resident #062 was placed on an identified duration of monitoring since another incident had occurred on the same day, and also one on one care had been provided during an identified date. The ADOC and the Administrator confirmed the home had not investigated the above mentioned incident as required.

2. The home submitted a CIS report on an identified date to the MOHLTC, Director, indicating resident to resident abuse by resident #004 to resident #002.

During the initial record review for resident #004, revealed resident #004 was also inappropriate towards resident #005 on an identified date.

An interview was conducted with resident #005 and the resident stated that during an identified time period and resident #004 exhibited an inappropriate responsive behaviour toward him/her.The resident indicated he/she reported the incident to RN #105 and informed the Interim DOC #156 immediately.

A review of the resident #005's electronic progress notes revealed documentation of the incident.

An interview with RN #105 stated it is the home's expectation when a resident reports an allegation of abuse, the staff are to report the allegation of abuse to the DOC and Administrator and an investigation is to be started by the home. The RN indicated resident #005 informed him/her of the above incident, which was the date the incident occurred. The RN further stated he/she reported the incident to the Interim DOC #156 and the Administrator immediately and was unaware if an investigation was done related to the incident. The RN stated he/she considers this incident to be abuse by resident #004 towards resident #005.

An interview with the Interim DOC #156 stated it is the home's expectation of the staff is that any suspected, witnessed allegation of abuse is to be reported to the DOC and/or Administrator and an investigation must be initiated immediately by management. The DOC acknowledged RN #105 did report the above incident to him/her on the same day the incident had occurred and considered the incident above to be abuse from resident #004 towards resident #005.

The inspector requested investigation notes of the incident from the Interim DOC who indicated an investigation was not completed as the Interim DOC identified resident #004 as having responsive behaviours when he/she had exhibited an identified responsive behavour towards resident #005. The Interim DOC indicated the home did not follow home expectation in ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

An interview with the Administrator indicated the home's expectation was any witnessed, suspected and or alleged abuse must be reported immediately and be investigated. The

Administrator revealed he/she was unable to recall if RN #105 reported the incident above to him/her. The Administrator stated an investigation should have been conducted and he/she considered the above incident to be abuse and the home did not follow the home's expectation to immediately investigate the allegation of abuse.

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 ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred must immediately report the suspicion and the information upon which it is based to the Director.

The home submitted a CIS report on an identified date to the MOHLTC Director indicating the morning of an identified date, PSW #101 observed resident #062 to be inappropriate with resident #063 in an identified location of the home. The incident was first reported to MOHLTC on an identified date, through the after-hours MOHLTC line.

An interview with PSW #101 indicated that on an identified date and meal, he/she observed resident #062 being inappropriate with resident #063. The PSW separated the residents and reported the incident to RPN #132.

An interview with RPN #132 indicated when he/she became aware of the above mentioned incident, he/she considered it to be abuse towards resident #063, and he/she reported the above incident to RN #118. The RPN confirmed he/she did not report the incident to MOHLTC.

An interview with RN #118 indicated he/she did not recall the details of how and when the incident was reported to him/her. The RN had no recollection of calling the after-hours numbers to report the incident above to the MOHLTC.

Interviews conducted with ADOC #156 and the Administrator indicated registered staff on the unit are responsible to report incidents to MOHLTC using the after-hours number immediately. The management staff would submit the CIS report when they returned to work after holidays. Since the incident was reported to MOHLTC by RN #118, the ADOC and the Administrator confirmed it was not reported immediately as required.

2. The home submitted a CIS report on an identified date to the MOHLTC Director, and called the MOHLTC after-hours line indicating resident to resident abuse involving resident #062 and #063 which had occurred on an identified date.

During further reviews of resident #062's progress notes indicated during an identified meal, RPN #132 observed resident #062 talking to resident #064 inappropriately. Resident #062 was informed that this behaviour was inappropriate. The above incident was not included in the CIS report to the MOHLTC Director, or through the after-hours MOHLTC line.

Review of resident #064's RAI-MDS assessment and plan of care indicated the resident was cognitively and physically impaired.

An interview with resident #064 indicated he/she had no recollection of the incident above.

An interview with RPN #132 indicated on an identified date, resident #062 exhibited an identified responsive behaviour towards resident #064 in an identified location of the home. The RPN indicated he/she considered the incident as abuse towards resident #064, and he/she recorded and reported the incident to RN #118. The RPN acknowledged he/she did not report the above incident to MOHLTC.

An interview with RN #118 indicated he/she had no recollection of the incident.

Interviews conducted with ADOC #156 and the Administrator indicated registered staff on the unit are responsible to report the incident to MOHLTC immediately using the after-hours number. The ADOC indicated he/she became aware of the incident after he/she returned from holidays and he/she considered the above incident to be abuse. The ADOC and the Administrator confirmed the incident was not reported to MOHLTC as required.

3. The home submitted CIS report on an identified date to the MOHLTC Director, indicating that on an identified date, former resident #065 reported to staff member that he/she called for assistance at an identified time of the day, and a staff member responded three hours later.

A review of resident #065's written plan of care indicated the resident required extensive assistance for care with one-person physical assistance.

A review of the home's investigation records indicated resident #065 reported to staff members that he/she requested assistance, but was not assisted until three hours later.

An interview with resident #065 stated he/she does not recall the details of the incident above.

An interview with PSW #164 revealed on an identified date, when he/she was providing resident #065 care the resident told him/her that the he/she had called assistance and no one responded to assist him/her till three hours later, and the resident stated his/her clothes and bed was unclean. The PSW suspected the resident had not been provided care for and he/she reported the incident to RN #137.

An interview with RN #137 indicated he/she spoke with resident #065 and the resident stated that he/she called for help and no one came to help him/her. After speaking with the resident, the RN stated he/she reported the incident to ADOC #156 on an identified date.

An interview with ADOC #156 indicated he/she became aware of the incident on an identified date, and he /she suspected resident #065 had not been provided with care and started an investigation on the same day. The ADOC confirmed the incident was reported to MOHLTC on an identified date, but not immediately as required.

4. The home submitted a CIS report on an identified date to the MOHLTC, Director, indicating resident to resident abuse by resident #004 to resident #002. The CIS further stated resident #004 was inappropriate towards resident #002.

An interview with resident #005 indicated he/she was going into an identified resident area of the home and resident #004 exhibited an identified responsive behaviour towards him/her. Resident #005 reported the incident to RN #105 and informed the Interim DOC #156 immediately.

An interview with RPN #195 indicated the home has zero tolerance for abuse and any incidences of abuse must be reported to the management and reported to the MOHLTC Director. The RPN indicated he/she witnessed resident #004 exhibited an identified responsive behaviour towads resident #005 on an identified date. The RPN further stated resident #005 was upset after the incident and considered the incident to be physical abuse and the incident should have been reported to the MOHLTC Director.

An interview with the IDOC #156 stated it is the home's expectation if there is any suspicion of abuse of a resident has occurred the incident is to be immediately report to the MOHLTC Director, and the home is to initiate an investigation. The IDOC indicated RN #105 reported the incident to him/her the same day of the incident and considered the incident to be abuse. The inspector reviewed the CIS reports the home submitted in the past and was not able to locate a CIS for the incident above. The IDOC acknowledged the home did not report the above incident to the MOHLTC Director, as per home's and MOHLTC expectation.

An interview with the Administrator indicated it was the home's expectation that any witnessed, suspected and or alleged abuse must be reported immediately to the MOHLTC Director, and investigated by the home. The Administrator revealed that he/she

was unaware of the above incident between residents #004 and #005 and acknowledged an investigation was not conducted and was missed by the home. The Administrator stated he/she considered the above incident to be abuse and the home did not follow the home's and MOHLTC expectations to immediately report the suspicion of alleged abuse to the MOHLTC Director.

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 ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred must immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours where possible.

The home submitted a CIS report on an identified date to the MOHLTC Director indicating the morning of an identified date, PSW #101 observed resident #062 to be inappropriate with resident #063 in an identified location of the home. The incident was first reported to MOHLTC on an identified date, through the after-hours MOHLTC line.

A review of resident #062's RAI-MDS assessment and plan of care indicated the resident had physical impairment and was independent with cognitive skills for daily decision-making.

A review of the resident #062's progress notes, documented by BSC #159, revealed the resident was observed to be inappropriate and was reminded not to do so with other residents unless they give him/her consent. One of the recommendations was to monitor resident for possible identified inappropriate behaviour of other resident unless consent was given by the other resident.

A review of resident #062's plan of care revealed no strategies where developed as recommended by the BSC to monitor resident for possible identified inappropriate behaviour towards other residents unless consent was given by the resident.

An interview with BSC #159 indicated resident #062 was referred to his/her care due to the resident's identified responsive behaviours after the resident was admitted. During his/her consultations with the resident he/she identified the resident had been giving away an identified item to other residents in the home and reminded the resident not to do so. During an identified time period, the BSC further identified the resident had possible identified inappropriate behaviours with other residents, and therefore made the above mentioned recommendation for monitoring the resident's behaviours. The BSC stated he/she did not develop any strategies for monitoring the resident and communicated the recommendation to nursing staff.

Interviews conducted with PSW #101 and #133, and RPN #147, indicated they did not recall any strategies had been developed and implemented for monitoring resident #062's possible identified inappropriate behaviours towards other residents according to the BSC's recommendations. RPN #147 indicated the resident was monitored for all behaviours same as other residents on the unit.

An interview with ADOC #156 indicated specific strategies should have been developed and implemented for monitoring resident #062's identified inappropriate behaviours towards other residents. RPN #147 and the ADOC confirmed that no strategies were

developed and implemented for monitoring the resident #062 identified behaviours.

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 ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours where possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action is taken as necessary, and a written record was kept.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating there had been a medication error which resulted in an adverse drug reaction involving resident #043.

Record review of the CIS and the clinical records indicated resident #043 resided on an identified area of the home and had returned from hospital with a identified diagnosis on an identified date. The resident returned to the home with a physician's order for an identified medication to be administered by mouth twice daily for five days. The CIS report further indicated that the medication was not entered into EMAR and the nurse on duty at the time of the resident's readmission administered the first dose of the medication on an identified date. The CIS report indicated the following eight doses of the medication had not been administered to the resident. Resident #043's health declined and was readmission to hospital with an identified diagnosis.

Review of the home's medication incident report relating to the above mentioned medication error indicated in the severity or outcome section on the report had not been completed by the registered staff. A further review of the medication incident report indicated page two had also not been completed by the DOC.

An interview with ADOC #106 confirmed that the medication incident report for the above had not been completed fully and further confirmed that the corrective action to prevent recurrence, signatures from the pharmacy and a facility evaluation had not been signed by the DOC/Administrator. The ADOC further confirmed that the above mentioned medication incident had not been reviewed or analyzed and corrective action had not taken place as the home had not completed the medication incident form.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

The license has failed to ensure that the records of the residents of the home are kept at the home.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating unlawful conduct which resulted in harm/risk of harm to a resident. A further review of the CIS report indicated resident #041 exhibited an identified responsive behavior toward resident #050.

A review of the clinical records indicated that resident #041 had entered an identified area of the home. A further review of the clinical records indicated resident #041 had exhibited an identified responsive behaviour toward resident #050.

The admission documentation indicated resident #041 had been admitted to the home with a cognitive impairment. The resident had recently been assessed prior to the above mentioned incident on an identified date, using the "Responsive Behaviour Risk Screening" tool and had been categorized as minimal to no risk for responsive behaviours.

A review of a Behavioural Support Services Mobile Support Team warm hand-off form, indicated that the mobile support team had completed a comprehensive behaviour assessment for resident #041 based on information collected from the home which had included a 14 day Dementia Observation Record (DOS).

The inspector reviewed clinical records and was unable to find DOS charting records for resident #041.

Interviews conducted with PSW #102, RPN #114 and RN #118, acknowledged that the DOS record had been completed for resident #041as part of the plan of care however the DOS charting records could not be produced at the time of the inspection.

Interviews conducted with RBL #159 and ADOC #156 acknowledged he/she was unable to locate the DOS record at the time of the inspection and further confirmed that the home had been unable to ensure that the records of the residents of the home were kept at the home.

Issued on this 15th day of September, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), JENNIFER BROWN (647), JOY IERACI (665), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2017_595604_0011
Log No. / No de registre :	019304-16, 022481-16, 024013-16, 026596-16, 028294-16, 028742-16, 029552-16, 030321-16, 030680-16, 031144-16, 034315-16, 034769-16, 035174-16, 004146-17, 004399-17, 004725-17, 004973-17, 005252-17, 007070-17, 009134-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 4, 2017
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

Linda Joseph-Massiah

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan and the plan shall include but is not limited to the following areas:

1) Re-education and training to all registered staff on the home's:
-Drug transcription policy and procedure
-Administration of medication specified by the prescriber

2) A system of auditing the transcription of physicians orders to ensure registered staff are compliant.

The plan shall be submitted by August 14, 2017, to shihana.rumzi@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), Director, indicating there had been a medication error which resulted in an adverse drug reaction involving resident #061.

Record review of the CIS report and the clinical records indicated that resident #061 was admitted to the home on an identified date. A review of the admission medication orders indicated the resident had an order for an identified medication for his/her identified diagnosis.

A review of the Electronic Medication Administration Record (EMARS) for an identified date, indicated that the admitting registered staff member transcribed an identified physician order. A further review of the EMARS for another identified date, indicated that resident #061 was administered eight doses of an identified medication 11 times in error on four identified dates.

An interview with the Associate Director of Care (ADOC) #106 indicated that all medication orders are to be checked by two registered staff members. The ADOC further indicated the first registered staff member is to transcribe the orders from the admission paperwork and the second registered staff member is required to cross reference what the registered staff member transcribed. The ADOC acknowledged that the new admission order form for an identified date, had not been checked by a second registered staff member to ensure the accuracy of the transcription.

An interview with the DOC acknowledged that resident #061 had not received the identified medication in accordance with the directions for use specified by the prescriber and therefore had to be transferred to the hospital on an identified date, with a decline in health status.

2. The home submitted a CIS report on an identified date to the MOHLTC Director, indicating a medication error had occurred resulting in an adverse drug reaction which involved resident #043.

Record review of the CIS and the clinical records indicated resident #043 resided in an identified care unit and had returned from hospital with an identified diagnosis on an identified date. The resident returned to the home with a physician's order with an identified medication which was to be administered daily for five days. The CIS report further indicated that the medication was not entered into EMAR and the nurse on duty at the time of the resident's readmission administered the first dose of the identified medication. The CIS report indicated the following eight doses of the identified medication had not been administered to the resident and his/her health declined and was readmitted to hospital on an identified date with an identified diagnosis.

Interviews with Registered Nurse (RN) #137 and Registered Practical Nurse (RPN) #138 both indicated resident #043 had returned to the home on an identified date, from the hospital with a new medication order which was to be administered daily for five days at change of shift. The registered staff indicated

that they had faxed the new medication order to the pharmacy and confirmed that they did not enter the medication or dosage into EMAR as required. RN #137 indicated he/she administered one dose of the identified medication to the resident from the home's emergency supply until the remaining doses were received from the pharmacy.

During an interview with RPN #138, he/she indicated he/she was on vacation and upon his/her return he/she reviewed the medication delivery records from Pharmacy. The RPN indicated he/she could not locate any confirmation that resident #043's prescribed medication had been received. The RPN stated he/she contacted the pharmacy and confirmed that they had not received the original order of the medication and therefore, had not sent it to the home. The RPN confirmed that the resident had only received one dose of the medication and had not received the prescribed eight doses as prescribed by the physician.

An interview with the Director of Care (DOC) acknowledged that resident #043 had not received the identified medication in accordance with the directions for use as specified by the prescriber and therefore had to be transferred back to the hospital, for further assessment and was diagnosed with an identified diagnosis.

The home is being served an order as two identified residents had not been administered their medications in accordance with the directions for use as specified by the prescriber, resulting in a change in health status. Resident #061 was administered 11 doses of an identified medication four times daily in error for four days. Resident #043 returned from hospital on an identified date with an identified medication order which was to be administered twice daily for five days. The resident received the initial dose and the remaining eight doses had not been administered. The resident's health declined and was sent to hospital for further assessment on an identified date.

The severity of the non-compliance and the severity of harm and risk where actual as resident #061 and #043 were not administered their medication as prescribed.

The scope of the non-compliance was pattern.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 131 (2), was

issued. The Non-compliances are as follows:
-Inspection #2013-162109-0045, Complaint Inspection – WN (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2017

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

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
Ontario, ON
M5S-2B1
Fax: 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
Ontario, ON
M5S-2B1
Fax: 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 4th day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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