Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2018	2018_642698_0006	026139-18	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

ORALDEEN BROWN (698), DEREGE GEDA (645), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 25, 26, 28, October 1, 2, 3, 4, 5, 8, 9, 10 and 11, 2018.

During the course of this inspection, the following Complaints, Follow-up, and Critical Incident System (CIS) intakes were inspected concurrently with the RQI:

-Complaint intake log #009940-18 related to medication administration;
-Complaint intake log #023647-18 related to staff to resident abuse;
-Follow-up intakes log #016549-18 and log #016557-18 (inspection 2018_631210_0009);
-CIS intake log #021399-18, CIS report #2586-000047-18 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Directors of Care (ADOC), Quality Improvement Coordinator (QIC), Business Office Manager, Social Worker (SW), Registered Nurses (RN), Nurse Consultant, Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapist Assistant (PTA), Pharmacist Consultant, Maintenance Technician, Resident Council (RC) president, Family Council (FC) president, family members and residents.

The inspectors conducted a tour of the resident home areas, observed medication administration, staff and resident interactions, provision of care, reviewed resident and home records, meeting minutes, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 253. (3)	CO #002	2018_631210_0009	645
O.Reg 79/10 s. 27. (1)	CO #001	2018_631210_0009	645

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term care (MOHLTC) indicating that on a specified date, most of the medications resident #014 was receiving before admission to the Long-Term Care Home (LTC), were discontinued or on hold. The family member of the resident visited the resident four days after admission and wanted to take the resident on a leave of absence. When they requested the medications they realized that most of the medications were discontinued. The family member discharged the resident from the home immediately. The resident's daughter reported to the home that the resident was transferred to hospital after the discharge from the home.

Review of the home's policy titled Medication Administration, policy #RCS F-80, dated on a specified date, indicated a process to prevent medication incidents on admission/readmission by documenting the best possible medication history from a minimum of two sources. The nurse will make a note in corresponding progress notes regarding changes prescribed by the Physician based on the presented medication history. The nurse will review the finalized Physician orders with the resident and or their family member and document the outcome of the conversation in corresponding progress notes.

Interviews with RPNs #112, #111 and #122 revealed the family member of resident #014 was not informed about the discontinuation of 11 medications and one medication placed on hold, on the day the resident was admitted to the home on an identified date. The resident was admitted for a planned short stay of approximately one month. According to RPN #123 when a resident is admitted or re-admitted to the home and medications are reconciled with the physician it is not a regular practice to inform the Substitute Decision Maker (SDM).

According to RPN #112 resident #014's family members were in the home during the medication reconciliation, and their assumption was that the unit RPN #122 would update the family. RPN #122 stated they did not inform resident #014's SDM about the medication reconciliation.

Interview with the SDM of resident #014 confirmed that they were not aware of the

change in medication and that they should have been informed.

Interview with ADOC #124 indicated that when resident medications were discontinued and if the duration of the medication administration was not defined during the medication reconciliation, it is considered a change in treatment. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #2: 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 :

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

A CIS report was submitted to the MOHLTC, indicating that on a specified date, most of the medications resident #014 was receiving before the admission, were discontinued or on hold. The SDM visited the resident four days after admission and wanted to take the resident for leave of absence. When they requested the medications they realized that most of the medications were discontinued. The family member discharged the resident from the home immediately. The daughter reported to the home that the resident was transferred to hospital after the discharge from the home.

A review of resident #014's clinical record indicated the resident was admitted on an identified date for a short stay of approximately one month.

Interview with RPN #112/Special Project Coordinator on a specified date, indicated that as part of their role is to be involved in the residents' admission process.

A review of the role description for the RPN/Special Project Coordinator revealed they are responsible to collect medication information and provide it to unit registered staff (RN/RPN) so nursing staff can complete medication reconciliation with the physician, follow up with the family as often as agreed at the admission meeting, calling them back to answer their questions and observe how effective interventions are. According to RPN #112, they checked the resident's vital signs and documented in the admission note that the resident was taking a specified treatment. They obtained resident #014's medication list given upon discharge from hospital on a specified date from the resident's daughter. There was no documentation and staff were unable to confirm whether the resident came to the Long Term Care (LTC) home from their home or from hospital. The resident's daughter asked RPN #112 to add an identified medication to the medication list.

According to the interview with RPN #122, who works on a casual basis, on the resident's admission day, they requested help from ADOC #124 with the new admission medication reconciliation for resident #014 because they were busy on the unit. ADOC #124 sent RPN #112 to help RPN #122. The unit RPN #122 indicated that the process was that the resident's medication list was to be confirmed with a family member by RPN #112/Special Project Coordinator. Interview with RPN #112 revealed contradictory information. They indicated that the medication list should have been confirmed by the unit nurse RPN #122.
Further, RPN #122 stated they wrote the medications from the hospital discharge list on the New Admission Order Form with the digi-pen and called the physician. The phone was on speaker and the physician was not clear about the medication list. The physician requested from RPN #122 to get another nurse to clarify the medications. Because no other nurse was available at that moment, RPN #122 asked RPN #123, who was sitting close by, to clarify the order. According to the interview with RPN #123 they confirmed the two discontinued medications on an identified date. RPN #123 indicated that she expected because the phone was on speaker and RPN #122 was listening that they would have taken the order down.

During the interview RPN #122 was not able to confirm how several identified medications were discontinued.

There is no documentation in the progress notes and electronic medication administration record (eMAR) that the resident was assessed for the use of a specified

treatment.

Interview with Pharmacy Consultant #110 indicated on a specified date, the DOC requested that they audit resident #014's medications. After the audit the Pharmacy Consultant sent a recommendation to the home on the day after the audit request, that resident #014 had an identified medical condition and certain specified medications should not be discontinued.

Interview with Administrator and ADOC #101 indicated that on a specified date, there were 15 registered staff and the DOC in the LTC home, when RPN #122 requested assistance with resident #014's admission medication reconciliation.

Review of the resident's progress notes revealed that RPN #112 followed up with resident #014's daughter who stated that the resident was sent to hospital on a specified date, and they could not understand why the medications were discontinued and the specified medication was not refilled.

Interview with the Administrator acknowledged that the medications for resident #014 should not be discontinued upon admission, and the role and responsibilities of the registered staff who were conducting resident #014's admission were not clear in regards to the admission medication reconciliation process. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for residents #025 and #026, were developed based on the interdisciplinary assessment of the residents special treatments and interventions.

On a specified date, residents #025 and #026 were observed in their rooms, and both residents' rooms had contact isolation precaution signs on the doors, and Personal Protective Equipment (PPEs) gowns and gloves placed by the entrance of their room doors.

Record review of the progress notes indicated that resident #25 and #26 had identified infections. Record review of the home s infection prevention and control policy manual, policy #IFC D-45, directed registered staff to document the specified infection treatments and list of appropriate interventions on residents' plan of care. Record review of the plan of care for both residents did not indicate documentation of the infection, associated treatments and interventions.

An interview with RN #136 confirmed that the specified treatments and interventions for resident #025 and #026 were not included in their plans of care. RN #136 reiterated that registered staff are expected to develop a plan of care for residents with the specified condition.

An interview with the ADOC #101 confirmed that the plan of care for both residents #025 and #026, did not include interventions related to the above mentioned specified infection. They confirmed that registered staff are expected to include the specified infection precautions, treatments and interventions in residents' plan of care. [s. 26. (3) 18.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information (such as copies of the inspection reports from the past two years for the long-term care home) were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulation.

Observation on a specified date during the initial tour of the home indicated that the Public Inspection Report #2018_631210_0009 and Order Report were not posted in the Public information binder that was located at the reception desk.

Interview with ADOC #101 indicated that all public reports sent to the home should be posted in the Public Information binder at the reception desk and acknowledged that the above named inspection reports were not posted. [s. 79.]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home's medication incident records revealed that on an identified date, a medication incident was recorded related to resident #013's medication administration. According to the record, an identified medication was discontinued on a specified date, and the resident was prescribed another medication. The registered staff administered the original medication instead of the new medication.

Interview with Pharmacy Consultant #110 revealed that the home faxed the medication incident report to the pharmacy but the name of the resident, the room number and the date was not included in the form. The pharmacist requested the additional information from the home, but the information was not received until after the inspector interviewed the Pharmacy Consultant. The Pharmacy Consultant indicated that every medication incident should be faxed to the pharmacy, in order for the pharmacy to initiate corrective action, prevent re-occurrence, and analyze trends at the monthly interdisciplinary meeting.

Interview with the home's Administrator and the Pharmacy Consultant acknowledged that the medication incident report from a specified date mentioned above, involving resident #013 was not faxed to pharmacy. [s. 135. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the initial tour on an identified date, Inspector #645 observed resident rooms 112 and 119 to be on specified infection precautions. The rooms were observed to have contact precaution signs and Personal Protective Equipment (PPE) gowns and gloves placed by the entrance to the rooms. The precaution signs directed staff members to wear appropriate PPE all the time when providing care to the above mentioned residents in the rooms.

On a specified date, PTA #106 was observed entering room 112 without donning the appropriate PPE (gown and gloves). PTA #106 was observed providing a specified treatment and transferring resident #025 from wheelchair to bed.

On a specified date, the above mentioned staff member was observed entering room 119 without donning a gown. PTA #106 was observed providing a specified treatment to resident #026.

On a specified date, PSW #103 was observed entering room 112 without wearing PPEs. The PSW was observed transferring resident #025 to bed without wearing gloves and gowns. They were also observed leaving the room and entering another room without washing their hands in between.

Interview with both staff members #103 and #106 confirmed that they did not wear the appropriate PPE while providing care to residents #025 and #026. Both staff members, #103 and #106, reiterated that staff are expected to wear appropriate PPEs when providing care to residents who are on specified treatments.

Interview with the ADOC confirmed that staff are expected to wear appropriate PPE all the time when providing care for residents who are identified to be on specified treatments. They confirmed that the above mentioned staff members did not participate in the implementation of the infection prevention and control program of the home. [s. 229. (4)]

Issued on this 22nd day of January, 2019

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

Original report signed by the inspector.