Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 25, 2020	2020_754764_0005	021935-19	Critical Incident System

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

NAZILA AFGHANI (764)

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): March 3, 4 and 5, 2020

During the course of inspection, Intake log #021935-19, was inspected related to Continence Care.

During the course of the inspection, the inspector(s) spoke with Assistant Director of Care (ADOC), Special Project Nurse (SPN), Registered Practical Nurses, Personal Support Workers (PSWs), Unit Clerk and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received specified personal care to remain clean, dry and comfortable.

Review of a CIS report indicated that on an identified date, specified personal care was not provided for resident #001.
Review of resident #001's clinical health records revealed that resident #001 required extensive assistance for a specified personal care.
Review of resident #001's plan of care indicated that specified personal care should be provided after each incontinent episode.
Review of a continence care assessment showed resident #001 had the ability to sense the urge to defecate.

Review of the Home's investigation report showed that on the identified date, PSW #103 indicated that they provided specified personal care for resident #001 once during their shift, but admitted they did not check if resident #001 needed the specified personal care again during their last round before the end of their shift.

During an interview with resident #001, they indicated that they can feel when they need the specified personal care. They stated that on the above mentioned identified date and time, they needed the specified personal care and used the call bell to call for help, but no one responded to the call. Resident #001 indicated the same type of incident occurred

a few weeks ago and they waited more than two hours to receive the specified personal care.
Resident #001 confirmed that they did not receive the specified personal care.

Interview with PSW #100 acknowledged that on the identified date, specified personal care was not provided to resident #001.

In summary, the licensee failed to ensure that resident #001 had specified personal care to remain clean, comfortable and dry when care was not provided before the end of the shift.

2. Review of a CIS report indicated on identified date and time, continence care was not provided for resident #002.

Review of resident #002’s clinical health records revealed that resident #002 required total care and the plan of care indicated that specified personal care should be provided for resident #002.

Review of the Home's investigation report showed that PSW #103 indicated that on the identified date and time, they provided the specified personal care for resident #002. PSW #103 admitted that they did not provide personal care for resident #002 on their round again, before the end of the shift although they knew the resident may need the specified personal care.

During inspector #647's interview, PSW #103 indicated that they provided specified personal care for resident #002 on the identified date and time, but they didn't remove or change the sheets under the resident.

Interview with PSW #100 reported that on identified date, they discovered on the oncoming shift, wet sheets under the resident #002. PSW #100 acknowledged that resident was not provided the specified personal care to remain clean and comfortable.

In summary, the licensee failed to ensure that resident #002 had specified personal care to remain clean, comfortable and dry.

1. The licensee has failed to ensure that the staff provided the correct size of incontinent product for resident #001.

Review of resident #001's clinical health records, revealed that resident #001 used an incontinent product.
Inspector # 764's interview with resident #001, revealed that sometimes the PSWs were providing them with the smaller size of incontinent product.

Review of progress notes by the home's incontinence lead, during their care plan rounds on a specified date, indicated that the assigned PSW provided resident #001 with the incorrect size of incontinent product as it was specified in the plan of care.
In interview, PSW #100 stated that they continue to use the same size of incontinent product that resident #001 had on from the prior shift without checking the plan of care.

Interview with ADOC #110 indicated that staff are expected to check the correct size of incontinent product in the resident's written plan of care before applying it to the residents. ADOC #110 acknowledged that correct size of incontinent product was not provided to resident #001 as specified in the plan of care.

As a result of non-compliance identified for resident #001, the sample was expanded to residents #009 and #015.

2. On a specified date, the inspector reviewed the floor incontinent product distribution list for a specified floor/unit, with the assigned PSW #106.
The distribution list and plan of care indicated that resident #009 should wear a size medium (blue) incontinent product, but PSW #106 acknowledged that resident #009 was wearing size small (white) incontinent product. Resident #009's plan of care, specified resident should use medium (blue) incontinent product.

Interview with ADOC #110 indicated that staff are expected to check the correct size of incontinent product in the resident's written plan of care before applying it to the residents. ADOC #110 acknowledged that correct size of incontinent care product was not provided to resident #009 as specified in the plan of care.

3. On a specified date, the inspector reviewed the current incontinent product distribution list for a specified floor/unit, with the assigned PSW #107.The distribution list indicated that the resident #015 should wear a size medium (blue) incontinent product, and PSW #107 acknowledged that the resident was wearing a blue incontinent product. The resident’s plan of care specified resident should use the small (white) incontinent product.

Interview with ADOC #110 indicated that staff are expected to check the correct size of incontinent product in the resident's written plan of care before applying it to the residents. ADOC #110 acknowledged that correct size of incontinent product was not provided to resident #015 as specified in the plan of care. [s. 51. (2) (g)]

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 residents have sufficient changes to remain clean, dry and comfortable, and are using the correct size of incontinent products, to be implemented voluntarily.

Issued on this 13th day of April, 2020

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

Original report signed by the inspector.