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
Feb 18, 2020	2020_816722_0002	019017-19, 021042-19, 023446-19, 000059-20, 000832-20	Complaint

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

COREY GREEN (722), JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 15-17, 20-24, and 27-31, 2020.

The following Complaints were inspected during this inspection:

- Log #019017-19 related to neglect, nutrition and hydration.
- Log #021042-19 related to resident discharge.
- Log #023446-19 related to hospitalization and change in condition.
- Log #000059-20 related to alleged abuse and skin and wound care.

A critical incident report (Log #000832-20) was also received by the Ministry of Long-Term Care (MLTC) related to the Complaint of alleged abuse identified in Log #000059-20. Information related to the critical incident was gathered as part of this Complaint inspection.

During the inspection, inspectors reviewed relevant home administrative records (e.g., audits, policies and procedures, etc.) and resident health care records; and made observations of residents and resident home areas.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Directors of Care (DOCs), Assistant Directors of Care (ADOCs), Food Services Manager (FSM), Registered Dietician (RD), Social Services Coordinator (SSC), Program Manager (PM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Dietary Aide (DA), residents' family members, and residents.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 WN(s)**
- **1 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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to resident #002's change in health status that required a transfer to hospital with intensive treatment in hospital and specified diagnoses.

In an interview, the complainant stated that on a specified date, they received a call at a specified time from registered staff in the home that resident #002 was transferred to hospital. The complainant called the home on their arrival to the hospital and was informed by a registered staff member that they were not able to obtain specified vital signs, but that another specified test result was "fine". A charge nurse assessed the resident, the physician was informed, and then resident #002 was transferred to hospital. The complainant stated that resident #002 received specified treatment in hospital and had a specified medical diagnosis.

Review of resident #002's electronic health record indicated that the resident had specified medical diagnoses, was transferred to hospital on a specified date, and returned to the home on nearly one month later.

Review of the hospital's documentation showed that resident #002 had specified health

conditions on admission and received specified treatment.

Review of resident #002's progress notes in the electronic health record identified the following entries by RPN #114 on the date the resident was transferred to hospital:
- Transferred to hospital for specified reasons that suggested deteriorating condition;
- At a specified time, resident was in a specified location in the home and was assessed; a specified test result was abnormal, the resident did not eat dinner, and swallowed very slowly when medication was administered;
- At a later specified time, resident had identified signs of a change in condition, including specified tests and vital signs that were abnormal or could not be measured;
- RN was called to assess the resident who advised RPN #114 to transfer the resident at a specified time; and
- At a later specified time, the paramedics were called and the resident was transferred to hospital.

In an interview, RPN #114 stated that at the beginning of their shift, resident #002 was in a specified resident home area and upon assessment the resident had signs that suggested deteriorating condition. The RPN indicated that the resident did not respond as per their usual baseline when they assessed resident #002. Three attempts were made to obtain a specified vital sign measurement which were unsuccessful, and the resident was transferred to bed. The resident had a specified vital sign that was abnormal, as well as three specified test results that were also abnormal, prior to their transfer to hospital. The RPN further stated that they called RN #123, the charge nurse, to assess the resident. When RN #123 assessed the resident, they had similar difficulties taking a specified vital sign measurement. The decision was made by RN #123 to transfer the resident to hospital. During the interview, RPN #114 indicated that RN #123 assessed the resident at a specified time and stayed with and monitored the resident.

In an interview, RN #123 stated that RPN #114 had notified them to assess resident #002 at a specified time approximately three hours after the initial abnormal findings were documented, as the resident was observed to have a specified change in condition. The RN indicated that when they get a request from the RPN to assess a resident, they will assess the resident right away. During the assessment, they confirmed that they were unable to obtain a particular vital sign measurement, and that the resident's condition had deteriorated in a specified manner. RN #123 stated that they called the physician and transferred the resident to hospital. The RN indicated that RPN #114 should have communicated their assessment of the resident at the start of the shift to implement interventions in the resident's plan of care to manage the resident's change in

health status.

In an interview, ADOC #103 indicated that when there was a change in a resident's health status, it was an expectation for the registered staff to frequently monitor the resident, and for the charge nurse and physician to be notified. The documentation was reviewed with the ADOC related to this incident, who acknowledged that the registered staff waited too long to transfer resident #002 to hospital when they were unable to obtain specified vital sign measurements over a specified period of time. The ADOC indicated that based on the documentation, no further checks were done by RPN #114 for several hours until RN #123 assessed the resident, and the physician was not notified right away by RPN #114.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #002 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with, when registered staff did not report alleged staff-to-resident abuse involving an identified staff member toward a specified resident.

A complaint was received by the MLTC related to an allegation of staff-to-resident abuse involving an identified staff member toward a specified resident. In the complaint, the resident's substitute decision-maker (SDM) alleged that a specified staff member had been abusive toward the resident in a specified manner.

The home's Abuse and Neglect Policy, Index ID #RCS P-10, with a last reviewed date of February 19, 2018, was reviewed, and indicated that where a staff member had reason to believe that a resident suffered harm or was at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information on which it was based, to the home.

The resident was interviewed by Inspector #722, and continued to allege that the staff member had acted in a specified abusive manner toward them. Based on the interview, resident's responses to questions, and further record reviews, it was not possible to substantiate the allegation of abuse.

The resident's family member, the complainant, was interviewed and indicated that at a specified time they had informed RN #105, charge nurse on the third floor of the home, that an identified staff member had acted in a specified abusive manner toward the resident, and that they no longer wanted that staff member providing care to the resident.

Review of the progress notes indicated that RN #105 had been notified on a specified date of a number of concerns from the resident's family member, including concerns that they did not want the identified staff member providing care to the resident for specified reasons. There was no indication in the note that the family member notified RN #105 of any specific concerns related to abuse. Another note entered by RPN #106 was identified on a later specified date, which indicated the SDM stated that they did not want the identified staff member to provide the resident care or they would call the police. There was no indication in the note that indicated why the SDM indicated they would call the police.

RPN #107 indicated during an interview that they were present in the room with RN #105 on the specified date when the resident's SDM expressed concerns about the identified staff member. RPN #107 stated that the SDM alleged that the staff member had acted in a specified abusive manner. RPN #107 indicated that they did not document or report the allegation of abuse to management because the unit charge nurse, RN #105, was present.

RPN #106 confirmed during an interview that they had entered the progress note identified above about the SDM calling the police, and acknowledged being aware that the SDM did not want the specified staff member to provide care to the resident. They acknowledged that the SDM was concerned about specific actions by the identified staff member. RPN #106 indicated that they explained to the SDM at the time why the resident may have perceived the staff member's actions as abusive. The RPN confirmed that they did not notify the charge nurse or management of the home of the specified allegation of abuse, as they questioned the resident's credibility for specified reasons.

ADOC #102 was interviewed, and indicated that they and the management team of the home were not notified by staff of the allegation of abuse involving the identified staff member toward the specified resident. They indicated that all staff in the home were expected, according to the home's policy, to report any alleged or suspected abuse towards a resident. They stated that staff were expected to notify the management staff in the home, or the on-call manager after-hours, for any such allegations so they could be addressed appropriately and reported to the MLTC. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The following findings under O. Reg. 79/10, s. 50(2) provide additional evidence for compliance order #002 issued on November 1, 2019, during complaint inspection #2019_767643_0027, with a compliance due date of March 18, 2020.

1. The licensee has failed to ensure that residents #006, #009, and #015, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was received by the MLTC on a specified date from resident #009's family member related to several concerns, including the resident's skin and wound care.

On a specified date during the inspection, Inspector #722 was accompanied by ADOC #103 and RN #105, to observe resident #001's skin. The resident was observed to have several alterations in skin integrity, including those listed below.

Review of the progress notes for a specified period indicated the following areas of altered skin integrity for resident #009:
- Location 1: identified in physician note on a specified date, and a note on a later specified date indicated that the resident's family member raised concerns about the

area of altered skin integrity to the registered staff.
- Location 2: identified by physician on a specified date, and treatment cream was prescribed.
- Location 3: several notes in January 2020 indicated that the was being treated in a specified manner by staff.
- Location 4: note on a specified date indicated that treatment was applied to the area, but the specific area (i.e., left/right) was not identified.

Review of the electronic treatment administration record (eTAR) indicated that treatment was initiated for Location 3 several months prior to the inspection start date.

The assessments were reviewed in the electronic health record for each of resident #009's alterations in skin integrity identified above. As of January 20, 2020, there were no assessments identified using the Skin & Wound Evaluation form, or any other clinically appropriate tool, for any of the locations specified above.

RPN #121 was interviewed and acknowledged that resident #009 had various alterations in skin integrity. RPN #121 confirmed that the Skin & Wound Evaluation tool was never used to assess the resident's areas of altered skin integrity specified above.

The sample was expanded to residents #006 and #015, who both had alterations in skin integrity, to determine the scope of the issue of non-compliance related to O. Reg. 79/10, s. 50(2)(b)(1).

Related to resident #015, review of the progress notes indicated that on a specified date registered staff documented that the resident had a specified alteration in skin integrity, which worsened over a specified period. The assessments were reviewed in the electronic health record for resident #015, and a skin and wound assessment using the Skin & Wound Evaluation tool was not identified for the area of altered skin integrity when it was initially discovered by staff on the specified date.

In an interview, ADOC #103 stated an assessment must be completed using the Skin & Wound Evaluation tool in the electronic health record by the registered staff who initially discovered the altered skin integrity. The ADOC confirmed that the skin and wound assessment tool was not completed when the altered skin integrity was initially discovered on the specified date.

Related to resident #006, review of the electronic health record indicated that the

resident had an identified chronic skin condition. Progress notes were reviewed and indicated that the skin condition started at a specified time several months prior to the inspection, resolved with specified treatment, and returned at a specified time just prior to the inspection start date. The electronic medication administration record (eMAR) was reviewed and verified that the resident was administered treatment at specified times for the skin condition, and was assessed by a dermatologist on a specified date.

Review of the assessments in the electronic health record indicated that there were no assessments of the resident’s alterations in skin integrity related to their skin condition identified using the Skin & Wound Evaluation tool, over a specified period of time during the first onset of the resident's skin condition. Review of the progress notes indicated that there were some assessment findings by registered staff documented on two specified dates during this period, as well as the documentation that the resident was assessed by the Dermatologist on a specified date.

RPN #104, the wound care lead, and RPN #117, were interviewed separately, and both confirmed that resident #006 had the identified skin integrity that originally started a specified period of time prior to the inspection, resolved for a period, and returned recently. Both RPNs reviewed the assessments in the electronic health record and were unable to identify when the condition started and resolved, as there were no assessments using the Skin & Wound Evaluation tool until the skin condition returned. RPN #104 further acknowledged that staff should have completed an assessment and taken a photograph of resident #006’s alterations in skin integrity associated with the skin condition when first identified a specified period of time earlier, and then completed weekly assessments using the tool.

RPN #104, the home’s Skin & Wound Care lead, as well as DOC #119, confirmed in separate interviews that any areas of altered skin integrity should have been assessed weekly by registered staff using the Skin & Wound Evaluation application on the mobile device, and a photograph taken of the area. They both indicated that this was the clinically appropriate tool the home had selected for completing skin and wound assessments and confirmed that the alterations in skin integrity described above for residents #006, #009, and #015 were not assessed with a clinically appropriate tool.

The licensee has failed to ensure residents #006, #009, and #015, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that residents #009 and #015, who exhibited altered skin integrity, were assessed by a registered dietitian who was a member of the staff of the home.

A complaint was received by the MLTC on a specified date from resident #009's family member related to several concerns, including the resident's skin and wound care.

Review of the progress notes indicated that resident #009 had seven specified areas of altered skin integrity that either reoccurred or were initially identified over a specified period of time. Review of the electronic treatment administration record (eTAR) and progress notes also indicated that the resident had another ongoing issue with a specified area of altered skin integrity that was being treated for a specified period of time. There were no referrals by registered staff to the Registered Dietician (RD) identified in the progress notes over this period related to altered skin integrity.

Review of the nutritional assessments in the electronic health record indicated that Registered Dietician (RD) #120 assessed the resident on a specified date for their quarterly review and interdisciplinary care conference, which indicated that resident #009's skin was intact. The next nutrition assessment was on a later specified date for the next quarterly review and interdisciplinary care conference, which identified that two specified areas of altered skin integrity were improving. The assessment indicated that resident #001's current diet was meeting nutritional and hydration needs for their skin issues.

RD #120 indicated during an interview that they did not receive a referral from registered staff between the quarterly assessments that were completed on specified dates. The RD said they could not comment on whether the resident's diet was meeting their nutritional needs related to the alterations in skin integrity detailed above, because they never received a referral during that period. They acknowledged that if they had received the referral, as per the home's usual process, they would have assessed the resident.

The resident sample was expanded to determine the scope of non-compliance associated with O. Reg. 79/10, s. 50(2)(b)(iii).

Review of the progress notes for resident #015 identified that the resident had a specified area of altered skin integrity that was initially identified on a specified date. There was no documentation in the progress notes which indicated that registered staff made a referral

to the RD at that time.

A review of the resident's skin and wound assessments in the electronic health record indicated that the identified area of altered skin integrity was identified as progressing on two later specified dates. Further review of the progress notes indicated that a referral was made to the RD on a later specified date, approximately a month after the altered skin integrity was initially identified, and the RD assessed the resident the following day.

In an interview, ADOC #103 reviewed resident #015's skin and wound assessments and progress notes and confirmed that a referral to the RD was not made upon initial discovery of the resident's altered skin integrity on a specified date, as per the home's process. RPN #104, the home's wound care lead, also indicated during an interview that resident #015's identified area of altered skin integrity should have been referred to the RD.

RPN #104, the home's wound care lead, and acting DOC #119, both indicated in separate interviews that a referral should have been sent by registered staff to the RD for resident #009 and #015's areas of altered skin integrity detailed above when they were first identified, so the residents could be assessed to ensure that their hydration and nutrition needs were being met. They both confirmed that the referrals were not submitted, and that the residents were not assessed by the RD when required for the altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that residents #006, #009, and #015, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when it was clinically indicated.

A complaint was received by the MLTC on December 31, 2019, from resident #009's family member related to several concerns, including the resident's skin and wound care.

On a specified date during this inspection, Inspector #722 was accompanied by ADOC #103 and RN #105, to observe resident #009's skin. The inspector was able to identify that resident #009 had five specified areas of altered skin integrity during the observation.

Review of the progress notes during a specified period of time indicated the following for resident #009 related to specified areas of altered skin integrity:
- Location 1: identified in physician note on a specified date; note on a later specified

date indicated that the resident's family member raised concerns about the area.
- Location 2: noted by physician on a specified date when they identified the area and ordered treatment; notes at the end of a specified period also indicated the resident's family members had raised concerns about the area.
- Location 3: identified by physician on a specified date and specified treatment was prescribed.
- Location 4: progress notes by physician and registered staff on a specified date verified that resident had the specified area of altered skin integrity; physician recommended specified treatment for the area.
- Location 5: progress note on a specified date indicated that the area of altered skin integrity was assessed; and identified in a note by registered staff on a later specified date.
- Location 6: several notes identified over a specified period referred to the treatment that registered staff were applying to the area.
- Location 7: progress note on a specified date indicated that specified treatment was provided by registered staff for this area of altered skin integrity.

Review of the eTAR indicated that treatment was initiated for altered skin integrity at Location 6 several months prior to the start of this inspection.

The progress notes and assessments were reviewed in the electronic health record for each of resident #009's alterations in skin integrity identified above, and weekly assessments were not identified either in progress notes or using the Skin & Wound Evaluation tool for each of the areas of altered skin integrity listed above over specified periods of time. Specifically, there were no weekly assessments identified for areas of altered skin integrity at Location 1 and 6 over a period of two months.

The eTAR was reviewed for a specified period of time related to skin and wound assessments. An entry was identified which indicated that weekly wound assessments were to be completed for resident #009 every Wednesday; however, no sites were specified in the order so it could not be used to verify that assessments were completed related to the alterations in skin integrity identified above.

RPN #121 was interviewed and acknowledged that resident #009 had various alterations in skin integrity. They explained that registered staff were expected to take a photograph and use an application on a mobile device to complete the initial and weekly assessments for any areas of altered skin integrity until the wound healed, which would get uploaded to the electronic health record. RPN #121 confirmed that the eTAR and

care plan for resident #009 did not specify the various alterations in skin integrity that should have been assessed each week, and confirmed that the weekly assessments were missing for the alterations in skin integrity detailed above.

RPN #104, the home's wound care lead, as well as DOC #119, confirmed that resident #009's skin alterations described above should have been assessed weekly by registered staff using the Skin & Wound Evaluation tool on the mobile device, and a photograph taken of the area. They both confirmed that the weekly skin assessments were missing for the periods specified and the alterations in skin integrity listed above.

The resident sample was expanded to include residents #006 and #015 to determine the scope of this non-compliance under O. Reg. 79/10, s. 50(2)(b)(iv).

Related to resident #015, review of the progress notes indicated that the resident had an area of altered skin integrity that was initially identified on a specified date. Review of resident #015's skin and wound assessments documented the progression of the area of altered skin integrity on two specified dates. Weekly assessments of resident #015's area of altered skin integrity were not identified for a specified period of approximately one month.

RPN #104, the home's wound care lead, confirmed in an interview that resident #015 had an area of altered skin integrity and that weekly assessments were not completed over a specified period by registered staff as per the home's process.

ADOC #103 reviewed resident #015's skin and wound assessments and progress notes and also confirmed in an interview that the home failed to ensure that weekly skin and wound assessments were completed for resident #015's altered skin integrity over the identified period.

Related to resident #006, review of the electronic health record indicated that resident #006 had an identified skin condition. Progress notes were reviewed and indicated that the resident had multiple areas of altered skin integrity associated with the condition over a specified period of time (months), and then resolved. The eMAR was reviewed and indicated that the resident was prescribed treatment by the physician on several occasions over a specified period of time, and was seen by a dermatologist on a specified date, related to the skin condition. The progress notes indicated that the skin condition returned several weeks prior to the inspection, and areas of altered skin integrity associated with the skin condition were observed by the inspector.

Review of the assessments in the electronic health record indicated that there were no assessments or photographs of the resident's areas of altered skin integrity identified using the Skin & Wound Evaluation tool prior to a specified date. The eMAR was reviewed and there were no orders to do weekly assessments of the resident's skin over the specified period when the skin condition initially occurred.

RPN #104, the wound care lead, and RPN #117, were interviewed separately, and both confirmed that the resident had the identified skin condition, that originally started several months ago and that resolved for a period and returned recently. Both RPNs reviewed the assessments and were unable to identify when the areas of altered skin integrity started and resolved, as there were no assessments using the Skin & Wound Evaluation tool until a later specified date when the skin condition recurred.

RPN #104 further acknowledged that staff should have completed an assessment and taken a photograph of resident #006's areas of altered skin integrity when they were first identified during a specified month, and then weekly using the tool. The RPN also acknowledged that there should have been an entry added to the eTAR to remind staff to complete the weekly entries.

DOC #119, the acting DOC, confirmed in an interview that resident #006's areas of altered skin integrity associated with the identified skin condition were not assessed using an appropriate clinical tool, and then weekly thereafter, as they should have been when they were first identified in an earlier specified month.

The licensee has failed to ensure that residents #006, #009, and #015, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when it was clinically indicated. [s. 50. (2) (b) (iv)]

Issued on this 28th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COREY GREEN (722), JOY IERACI (665)
Inspection No. / No de l'inspection :	2020_816722_0002
Log No. / No de registre :	019017-19, 021042-19, 023446-19, 000059-20, 000832-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 18, 2020
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must be compliant with s. 6(4)(b) of the LTCHA.

Specifically the licensee must ensure that RPN #114 and any other registered staff collaborate with the registered nurse (RN) in charge and physician as per the home's process when there is a change in health status for resident #002 and all other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to resident #002's change in health status that required a transfer to hospital with intensive treatment in hospital and specified diagnoses.

In an interview, the complainant stated that on a specified date, they received a call at a specified time from registered staff in the home that resident #002 was transferred to hospital. The complainant called the home on their arrival to the hospital and was informed by a registered staff member that they were not able

to obtain specified vital signs, but that another specified test result was "fine". A charge nurse assessed the resident, the physician was informed, and then resident #002 was transferred to hospital. The complainant stated that resident #002 received specified treatment in hospital and had a specified medical diagnosis.

Review of resident #002's electronic health record indicated that the resident had specified medical diagnoses, was transferred to hospital on a specified date, and returned to the home nearly one month later.

Review of the hospital's documentation showed that resident #002 had specified health conditions on admission and received specified treatment.

Review of resident #002's progress notes in the electronic health record identified the following entries by RPN #114 on the date the resident was transferred to hospital:
- Transferred to hospital for specified reasons that suggested deteriorating condition;
- At a specified time, resident was in a specified location in the home and was assessed; a specified test result was abnormal, the resident did not eat dinner, and swallowed very slowly when medication was administered;
- At a later specified time, resident had identified signs of a change in condition, including specified tests and vital signs that were abnormal or could not be measured;
- RN was called to assess the resident who advised RPN #114 to transfer the resident at a specified time; and
- At a later specified time, the paramedics were called and the resident was transferred to hospital.

In an interview, RPN #114 stated that at the beginning of their shift, resident #002 was in a specified resident home area and upon assessment the resident had signs that suggested deteriorating condition. The RPN indicated that the resident did not respond as per their usual baseline when they assessed resident #002. Three attempts were made to obtain a specified vital sign measurement which were unsuccessful, and the resident was transferred to bed. The resident had a specified vital sign that was abnormal, as well as three specified test results that were also abnormal, prior to their transfer to hospital.

The RPN further stated that they called RN #123, the charge nurse, to assess the resident. When RN #123 assessed the resident, they had similar difficulties taking a specified vital sign measurement. The decision was made by RN #123 to transfer the resident to hospital. During the interview, RPN #114 indicated that RN #123 assessed the resident at a specified time and stayed with and monitored the resident.

In an interview, RN #123 stated that RPN #114 had notified them to assess resident #002 at a specified time approximately three hours after the initial abnormal findings were documented, as the resident was observed to have a specified change in condition. The RN indicated that when they get a request from the RPN to assess a resident, they will assess the resident right away. During the assessment, they confirmed that they were unable to obtain a particular vital sign measurement, and that the resident's condition had deteriorated in a specified manner. RN #123 stated that they called the physician and transferred the resident to hospital. The RN indicated that RPN #114 should have communicated their assessment of the resident at the start of the shift to implement interventions in the resident's plan of care to manage the resident's change in health status.

In an interview, ADOC #103 indicated that when there was a change in a resident's health status, it was an expectation for the registered staff to frequently monitor the resident, and for the charge nurse and physician to be notified. The documentation was reviewed with the ADOC related to this incident, who acknowledged that the registered staff waited too long to transfer resident #002 to hospital when they were unable to obtain specified vital sign measurements over a specified period of time. The ADOC indicated that based on the documentation, no further checks were done by RPN #114 for several hours until RN #123 assessed the resident, and the physician was not notified right away by RPN #114.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #002 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The severity of this issue was determined to be a level 3 as there was actual

harm to the resident. The scope of the issue was a level 1 as this specific non-compliance was identified for one resident during the inspection. The home had a level 3 compliance history as there was previous non-compliance to the same subsection that included:
- Voluntary Plan of Correction issued August 4, 2017 (2017_595604_0011);
- Written Notification issued September 11, 2017 (2017_527665_0004); and
- Compliance Order #003 issued November 29, 2017, with a Compliance Due Date of January 12, 2018 (2017_644507_0016). (722)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

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