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
Jul 2, 2020	2020_754764_0006	002456-20, 007958-20	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

NAZILA AFGHANI (764), IVY LAM (646)

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): Onsite inspection conducted May 13, 2020. Offsite inspection was conducted on May 14, 15, 19, 20, and 21, 2020.

During the course of the inspection, intake log #002456-20 related to falls and personal support services and intake log #007958-20 related to hospitalization and change in condition were inspected.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses, Personal Support Workers, Nursing Coordinator and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that after resident #001 had a fall, a post fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of a complaint received by the Ministry of Long-Term Care (MLTC) on an identified date, indicated that fall prevention measures were not in place when resident #001 had a fall that resulted in fracture on identified date, and was not assessed. After discharge to their home, due to continued pain, the family doctor of resident #001 ordered a diagnostic test which featured an injury.

Review of resident #001's clinical health records, revealed that resident #001,needed extensive assistance, one-person physical assist to move between surfaces.
Review of the resident's Fall assessment tool stated that resident was at medium risk for falls.

Review of plan of care, indicated fall prevention measures such as using the floor mat and call bell within reach.

Review of resident 001's progress notes indicated:
- On an identified date and time, RPN #118 documented that, resident #001 had a witnessed fall, found on the floor mat leaning on the bed. They indicated no bruise or injury noted at that time and resident #001 had slight pain to an identified body part. All fall prevention measures were in place.

- On an identified date and time, resident #001 had pain in their back and requested a diagnostic test to be
done.
- On a second identified date and time, physician ordered the diagnostic test which was done on the same day.
- On a third identified date and time, diagnostic test revealed no negative results.
- On a fourth identified date and time, resident #001 was discharged home.
- On a fifth identified date and time, resident #001's diagnostic test results were faxed for their family doctor.
- Between the first and fifth identified dates, resident #001 complained of pain.

Review of the resident's Fall assessment tool indicated no Fall assessment was

completed after they had fallen .

Interview with PSW #121 stated that resident #001 was at risk for falls, had fall prevention measures in place and they used to assist the resident to the washroom.

Interview with RPN #118 indicated that resident #001 ambulated by themselves, although instructed to call for help. RPN #118 stated that on the identified date, the resident had a fall when they tried to ambulate by themselves; they were found on a floor mat near their bed.
RPN #118 confirmed that they started the documentation, but they did not complete the post fall assessment.

Interview with interim Assistant Director of Care (ADOC) #116, indicated that a post fall assessment should be completed for each resident who has fallen. ADOC #116 confirmed that staff did not complete a post fall assessment for resident #001 after they had fallen. [s. 49. (2)] (764)

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person designated by the resident #002, immediately received the information concerning hospitalization of the resident. s 3. (1) 16.

Review of a complaint received on an identified date, indicated that resident #002 was sent to the hospital and family were not informed about this transfer. Family were concerned when resident #002 did not attend an appointment which was booked for an identified date and time. The family later found that resident #002 was transferred to the hospital, and they were not informed about this transfer. After searching for resident #002 in the hospital, complainant found the home did not provide Substitute Decision Maker (SDM) contact information to the hospital upon the resident's transfer.

Review of resident #002's clinical records indicated an identified diagnosis with poor control.

Review of the plan of care indicated resident #002 is potential for specified changes related to their specified diagnosis. In the plan of care, the following interventions were listed:
- Using the holistic perspective of continued monitoring of resident for management of changes to health status.
- Monitor specified test results as per MD order
- Administer medication as per MD order. Monitor effectiveness and for side effects.

Review of the test results during an identified six week period revealed fluctuations in a specified range.

Review of Progress notes indicated on an identified date and time, RPN #104 recorded that they received a report that resident #002's test result was high, at the beginning of their shift, and although the last shift left a message for the physician, there was no call back from them. RPN #104 recorded that a subsequent test check for resident #002 was even higher. They were able to contact the physician on call and received orders. RPN #104 tested resident #002 again and found the test result continued to increase. RPN #104 tried to reach the physician on call, and as there was no response, contacted the administrator who instructed them to send the resident to hospital. Resident #002 was then transferred to the hospital.

During the following shift, RN #124, documented that the SDM was informed about resident #002's transfer to the hospital.

Interview with RPN #104 stated, they received the information from the last shift that resident #002 was not doing well and their test result was very high. The transfer decision was initiated as resident #002's test result was very high and they did not respond to the interventions. RPN #104 confirmed that they printed the transfer form to be sent to hospital with the resident, but they did not add any information regarding the SDM contact number as they thought it is included in the transfer form when it will be printed. RPN #104 confirmed that they did not inform the SDM of the resident's transfer and reported it to the next shift.

Inspector #764 did a trial run and printed a copy of resident #002's transfer form during the inspection and found the SDM contact number was not specified.

The acting Director of Care (DOC) confirmed that the transfer form did not specify the SDM contact number.

Interview with Nursing Coordinator #122 acknowledged that the home had an RN in charge in the building, but resident #002's unit had no coverage for registered staff on the identified date and time of the following shift.

In interview with interim Assistant Director of Care (ADOC) #116 stated that when a decision is made for a resident to be transferred to the hospital, the SDM should be notified immediately. ADOC #116 confirmed that staff didn't meet the expectation to notify the SDM about resident #002's transfer to hospital. [s. 3. (1) 16.] (764)

Issued on this 8th day of July, 2020

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

Original report signed by the inspector.