Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
TORONTO, ON, M4V-2Y7
Telephone: (416) 325-9297
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
TORONTO, ON, M4V-2Y7
Téléphone: (416) 325-9297
Télécopieur: (416) 327-4486

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 26, 27, Aug 30, Sep 27, 28, 29, 30, Oct 3, 4, 2011	2011_101174_0004	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

NANCY A. BAILEY (174)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator
Clinical Nurse Consultant
Registered Nurses
Personal Support Workers
Environmental Manager

During the course of the inspection, the inspector(s) Report #2011_101174__004/ T-1585-11
#2011_101174__005/ T-1596-11
#2011_101174__003/ T-1573-11
#2011_101174__007/ T-1764-11
Toured the home to review the heat levels in each resident home area
Observed the areas where air conditioning was available in the home
Observed fluid carts on resident home areas
Reviewed the Hot Weather Related Policy in the home with the Corporate Nurse Consultant
Reviewed the temperature monitoring sheet with the Environmental Manager, Administrator and Corporate Nurse Consultant.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Nutrition and Hydration

Safe and Secure Home

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following subsections:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. Report #2011_101174__004/ T-1585-11
#2011_101174__005/ T-1596-11
#2011_101174__003/ T-1573-11
#2011_101174__007/ T-1764-11

The licensee of the home did not ensure that the written hot weather related illness prevention and management plan for the home met the needs of the residents and was developed in accordance with evidence based practices and that it was implemented when required to address the adverse effects on residents related to heat.
Review of the home's Hot Weather Related Policy On July 25th, 2011 confirmed the following information following discussion with the Administrator, Corporate Nurse Consultant and Environmental Manager:
The home's Hot Weather Related Illness Policy G-20 stated that it was to be put into effect during periods of extreme heat when the Humidex of the home can not be maintained below 29 degrees Celsius.

2. Following review of the Daily Air Temperature Log, it was confirmed with the Administrator, the Corporate Nurse Consultant and the Environmental Manager that The Environmental Manager was only recording the air temperature of the home during the month of July not both the air temperature and humidity to establish the humidex reading as the homes daily air temperature log did not require humidity readings to be recorded, and he had not been instructed by the Administrator to take the humidity reading and how to calculate the humidex in the home areas.

The procedure for monitoring the humidex was not made available to the front line staff so that they could calculate the risk factor of the humidex reading in the home until mid afternoon on July 27, 2011

3. The afternoon of July 27, 2001 following the Corporate Nurse Consultant meeting with the Registered staff to instruct them on the revised policy of the home for monitoring temperatures and humidity to calculate the humidex of the home, the Charge Nurse on 3rd floor calculated the humidex as 33 degrees Celsius, yet there were no extra fluids brought to the units from the dietary department and the nursing staff had not called down to get them brought up. Additional fluids were not served to the residents until they were entering the dining room for supper at approximately 430 pm.

4. During at tour of the home on July 25, 2011 at approximately 1100, it was found that the air conditioner in the first floor dining room stopped working on July 25, 2011. It was not reported when it stopped working but the registered staff and Personal Support Worker confirmed it was not working during the breakfast meal. The registered nurse did not report this to maintenance even though the dining room was a cooling center in the home to provide residents with relief from the hot environmental temperatures.

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 the home's written Hot Weather Related Illness Prevention and Management Plan meets the needs of the residents and is developed in accordance with evidence based practices and is implemented when required to address adverse effects of residents related to heat., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Report # 2011_101174_0004 /T-1585-11

Documentation in the clinical record for 4 identified residents does not indicate that the residents were being assessed for signs of dehydration during heat temperatures in the home, prior to the physician assessing the residents and finding them to be dehydrated with possible electrolyte imbalance and requiring transfer to hospital where the residents were admitted for dehydration.

2. Report # 2011_101174_007 /T-1764-11

Documentation in a resident's clinical record does not indicate that the resident was being assessed for signs of dehydration prior to the resident being found poorly responsive, dehydrated, lethargic and profusely sweating. Documentation does not indicate what alternative treatments where being done as part of the home's hot weather program prior to this episode when the physician order the resident's transport to hospital for dehydration and electrolyte imbalance and they were admitted to hospital with dehydration.

3. Report # 2011_101174_005 /T-1596-11

The clinical records for 3 identified residents who were assessed as high risk for heat related illness on May 1, 2011 did not have documentation in the clinical record that the staff had assessed them for signs of dehydration or other effects of heat environmental temperatures or that alternative actions were considered prior to the residents being assessed as requiring transport to hospital.

An ideintified had been previously assessed in May 2011 as being at high risk for heat related illness. There was no referral to the dietitian for a reassessment related to concerns regarding intake from the family prior to the resident being sent to hospital with dehydration, Documentation does not support that the resident was consuming adequate fluid as per the nutritional assessment.

4. Report # 2011_101174_003/ T-1573-11

An identified resident who was previously assessed as moderate risk for heat related illness had been also assessed by the dietitian for the a nutritional risk for dehydration related to medications. The regular nutritional plan stated to monitor this resident for dehydration, yet during the heat temperatures July 21-17, 2011 this resident's clinical record does not include documentation to support that the staff were monitoring the resident for dehydration.

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 all residents who have been assessed as high risk for hot weather related illness are assessed for risk factors and effects of heat as per the home's hot weather related illness policy and that the assessments are documented., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Report #2011_101174__004/ T-1585-11
#2011_101174__005/ T-1596-11
#2011_101174__003/ T-1573-11
#2011_101174__007/ T-1764-11

Review of the home's policy for Hot Weather Related Illness policy #G-20 on July 25, 26, 2011 with the Corporate Nurse Consultant confirmed that the home was not following the following areas of the home's current policy and that the policy was currently under revision in the home.

1. As per procedure #9 the home did not " institute intake and output records on high -risk and moderate - risk residents when the indoor humidex reading was above 29 decrees Celsius";
2. As per procedure #11, the home did not document "a baseline TPR being established for high risk residents when the home had reached a humidex of 29 degrees Celsius and follow up treatment provided as necessary";
3. As per procedure # 14, the home did not start "detailed documentation as soon as any resident exhibits signs of any distress from the heat";
4. As per procedure # 16, the home did not conduct an " Annual evaluation of the home's plan in place to respond appropriately to hot weather conditions. This plan needs to be reviewed annually and communicated to staff, families and residents";
5. As per procedure #17, the home's plan did not include:
   (a) Annual staff education and training on prevention and management of heat related illness and hot weather plan"
   (c) Community based services which can assist the home with temporary heat relief strategies during extreme heatconditions;
   (f) The Dietary department to evaluate the need to have in hand specialty products to address the need for electrolyte replacement as necessary;
   (h) Environmental Manager to assess indoor temperatures and humidex levels at least once daily and use humidex tables and measurement strategies, and report humidex readings 29 degrees Celsius or higher.

2. The home's Policy for hot weather related ilness G-20.16, states " the home must have a plan in place to respond appropriately to hot weather conditions. This plan needs to be reviewed annually and communicated to staff, families and residents".
G20.17, states "the annual plan must include at a minimum the following:
a. Annual staff education and training on prevention and management of heat related illness and hot weather plan.
b. Cooling equipment in plance and other resources.
c. Community based services which can assist the home with temporary heat relief strategies during extreme heat conditions.
f. The dietary department to evaluate the need to have in hand specialty products to address the need for electrolyte replacement as necessary.
h. Environmental Manager to assess indoor temperatures and humidex levels at least daily and use humidex tables and measurement strategies, and report humidex readings is 29.0 or higher.

Interviews with the Administrator and Corporate Clinical Nurse Consultant on July 25 and 26, 2011 confirmed that education of the staff prior to the environmental heat alert had not occurred. The licensee had not reviewed the home's Hot Weather Related Illness policy prior to the hot temperatures occurring to ensure that all the tools were available for staff and that all staff were aware of the contents of the policy.
The Corporate Clinical Nurse Consultant also stated that the corporate office was not aware that the home's policy did

not have all the systems in place to manage the hot weather related risks to the residents and that the Dietitian and other necessary resources were not contacted as per the current policy to determine a plan for residents with altered fluid requirements in the home and to evaluate the need for specialty products to address the need for electrolyte replacement if necessary.

The Environmental Manager confirmed that he had not been informed of the need to take the humidity readings in the home and did not have the calculation graph in order to determine the home's humidex.

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 with ensuring that the home complies with the policy and procedure for heat related illness., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The electric fans in unit hallways were quite dusty and required cleaning when observed at 1100am July 26, 2011. Residents individual fans also were dusty and required cleaning even though they were running 24 hours per day due to the hot weather.

Issued on this 4th day of October, 2011

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

Nancy A Bailey