Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: February 27, 2024
Inspection Number: 2024-1317-0001
Inspection Type: Critical Incident (CI)
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Harmony Hills Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2024.03.06 10:03:12 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, 23, 26, 2024

The following intake was inspected:

- Intake: #00101475, related to a fall with injury.

The following intake(s) were completed in this inspection:

- Intakes: #00101001 and #00101236, both related to falls.

Inspector Safi Mohamed (000826) was present during this inspection.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and the plan of care revised when the care set out in the plan had not been effective related to falls.

Rationale and Summary

The home submitted a CI to the Ministry of Long-Term Care (MLTC) related to a fall the resident had with injuries.

The resident was assessed to be at risk of falls and had a history of falls. An intervention had been in place for many months at the time of the CI. The intervention was not on the resident at the time of the fall. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated that the resident

had a history of removing the intervention.

The RPN and the Associate Director of Care (ADOC)/Falls Lead verified that that the intervention was not effective and the plan of care was not revised after the resident's previous falls.

There was a potential risk of harm to the resident when the their plan of care was not revised when the intervention was not effective to prevent and manage their falls.

Sources: Review of CI report, a resident's clinical records; and interviews with a PSW, RPN and ADOC. [665]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that a resident, who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

The resident sustained an area of altered skin integrity and received treatment for a

few weeks.

Weekly assesments were not completed when treatment was provided.

The ADOC/Skin and Wound Lead verified that the weekly assessments were not completed as per the home's skin and wound program.

Failure to conduct weekly assessments of the resident's altered skin integrity may have prevented the home in monitoring the effectiveness of the treatment and interventions to promote healing.

Sources: Review of a resident's clinical records; and interviews with ADOC and other staff. [665]