Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 20, 2018	2018_558123_0003	029275-16, 031794-16, 006771-17, 008044-17	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

Long-Term Care Home/Foyer de soins de longue durée

Dundurn Place Care Centre
39 Mary Street HAMILTON ON L8R 3L8

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

MELODY GRAY (123)

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): February 6, 7 & 8, 2018.

The Inspector reviewed the home's records including Critical Incident reports and policies and procedures; reviewed residents' records and made observations.
The following Critical Incident (CI) reports were included in this inspection:
Log #029275-16 for CI #2739-000039-16 related to falls
Log #031794-16 for CI #2739-000047-16 related to falls
Log #008044-17 for CI #2739-000017-17 related to a falls
Log #006771-17 for CI #2739-000013-17 related to injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), registered staff, program staff and the Directors of Care (DOCs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

The home's record including Critical Incident report #2739-000013-17 was reviewed and it indicated that on an identified date in March, 2017, resident #003 had an un-witnessed fall. They were assessed after the fall and no injuries were noted. The following day the resident complained of pain and was assessed by the physiotherapist. The resident continued to complain of pain and the physician requested an identified diagnostic test to be completed. The test was completed the following day and results indicated the resident had an identified injury. The resident was transferred to the hospital for treatment.
The resident's record was reviewed. The physiotherapy progress note of an identified date in December, 2016, included: The physiotherapist assessed the resident and informed the registered staff that the resident would benefit from an identified device as well as other interventions. The Interdisciplinary Plan of Care Review progress note documentation of an identified date in February, 2017 noted the resident used the device when using their mobility equipment. The resident also received physiotherapy treatments.
Progress note documentation of an identified date in March, 2017 indicated that the resident fell from their mobility equipment and was discovered on the floor beside their mobility equipment by a co-resident. The staff were called and they transferred the resident back to their mobility equipment and then to bed.
The resident's care plan was reviewed and it did not include any information related to the resident's use of the identified device.

DOC #101 was interviewed by telephone and confirmed that the identified device was not included in resident #003's care plan. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
The home's record including Critical Incident report 2739-000013-17 was reviewed and it indicated that on an identified date in March, 2016, resident #003 was found on the floor beside their mobility equipment. The resident was assessed and no injury was noted at the time. The following day, the resident complained of pain in an identified area of their body. They were assessed by the physiotherapist and continued to complain pain in their body. The physician ordered an identified diagnostic test which was performed and the result indicated they had an identified injury.
The record of resident #003 was reviewed including the progress notes and it was noted that at the time of the fall, they used an identified piece of equipment for mobility. They were dependent on staff for all care and portering and they required the use of a mechanical lift for transfers. They needed three identified interventions when using their mobility device.
DOC #101 was interviewed and reported that they investigated the incident and the registered staff indicated the staff reported when the resident was found an identified intervention was not in place as per the plan of care.
The home did not ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in their plan. [s. 6. (7)]

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 a written plan of care for each resident that sets out, the planned care for the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The record of resident #001 was reviewed including the hospital Consultation Report of an identified date in September, 2016 and it was noted that the resident was abused by a co-resident at the home. The summary noted that they were assessed for an identified injury after abuse. There were hand written notes on the report indicating "not true, un-witnessed fall and untrue."
The Director of Care (DOC) #102 was interviewed and reported that the hospital staff documented the statement about resident as a result of information provided to them at the time of transfer by the registered staff of the home. The DOC indicated that they investigated the alleged physical abuse and the registered staff who spoke with staff at the hospital made a suggestion that the resident may have fallen as a result of being pushed or hit by resident #005. The fall may have occurred for a number of other reasons. The investigation found that the staff did not witness the incident.
The DOC provided the home's record of the investigation into the suspected abuse and the information was noted as they had previously communicated to the Inspector.
The DOC confirmed that the suspected abuse incident was not reported to the Director.
The home did not report the suspected physical abuse of resident #001 by resident #005 and the information upon which it is based on to the Director. [s. 24. (1) 2.]

Issued on this 29th day of March, 2018

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

Original report signed by the inspector.