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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 26, 2020 | 2020_824765_0004 | 019977-19, 020119-19 | Critical Incident System |

### 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

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

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

HILARY ROCK (765), MICHELLE BERARDI (679)

## 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 19 - 21, 2020.**

**The following intakes were completed in this Critical Incident System Inspection: One intake related to alleged staff to resident abuse and one intake related to a resident fall.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Clinical Director of Care (CDOC), Staff Development Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.**

**The inspector(s) also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff to resident #003 abuse during specified care on a specified date.

Inspector #765 reviewed resident #003's care plan at the time of incident which indicated they required specified assistance by two staff members for their specified care.

Inspector #765 reviewed the home's policy titled "resident assessment and care plan" last revised August 13, 2019, which indicated that residents would receive care based on their identified needs and would collaborate in their plan of care.

In an interview with Personal Support Worker (PSW) #107, they stated that they were the only staff member assisting resident #003 with their specified care at the time of the incident. PSW #107 indicated that they used Point Of Care (POC) to identify how many staff a resident required during care.

Inspector #765 and Registered Nurse (RN) #110 reviewed the Kardex and care plan in place on a specified date, and RN #110 confirmed that resident #003 was required to have two staff members assist with their specified care.

In an interview with Clinical Director of Care (CDOC) #102, they stated to Inspector #765 that resident #003 required two staff members for their specified care. CDOC #102 confirmed that there was only one staff assisting resident #003 at the time of the incident on a specified date.

b) During an observation on a specified date, Inspector #765 observed PSW #106 assist resident #004 alone for their specified care.

Inspector #765 reviewed resident #004's care plan which indicated that they required specified assistance by two staff members for their specified care.

In an interview with PSW #106, they stated to Inspector #765 that they were made aware of the care needs of a resident by looking at the Kardex. PSW #106 stated that resident #004 required two-person assistance for their specified care, but they usually assisted them on their own. PSW #106 confirmed that they assisted resident #004 alone for their specified care on a specified date.

In separate interviews with PSW #111 and Registered Practical Nurse (RPN) #109, they

confirmed that resident #004 required two-person specified assistance with their specified care.

In an interview with CDOC #102, they stated to Inspector #765 that resident #004 required two staff members with specified assistance for their specified care. CDOC #102 stated that if the care plan indicated two staff assistance then two staff were required to assist the resident. [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 the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.***

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**Issued on this 26th day of February, 2020**

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

**Original report signed by the inspector.**