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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2020	2020_689586_0006	002822-20, 003006-20, 003204-20	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

JESSICA PALADINO (586)

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 26, 27, 28 and March 2, 2020.

The following Critical Incident System (CIS) Inspections were completed concurrently:
003204-20 - Prevention of Abuse & Neglect;
002822-20 - Hospitalization & Change in Condition; and,
003006-20 - Falls Prevention & Management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Director of Care (CDOC), Social Services Worker (SSW), Resident Assessment Instrument (RAI) Co-ordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed resident care and reviewed resident health records, internal investigation notes and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care included the planned care for the resident.

According to CIS #2739-000007-20, submitted to the Director on an identified date in 2020, resident #003 experienced a fall with injury.

The Risk Management report and progress note post-fall indicated that two specific falls interventions were in place at the time of the fall. In an interview with RPN #111, who assessed the resident post-fall, they confirmed that these interventions were in place at the time of the fall, and had been for some time now.

A review of resident #003's written plan of care at the time of the fall, which front line staff used to direct care, did not include the use of these interventions. These interventions were added on an identified date in 2020, 22 days post-fall, by RAI Co-ordinator #112. In an interview with the RAI Co-ordinator, they said that once the resident returned to the home, they reviewed the incident notes and recognized that these interventions were not in the resident's written plan of care, so they added them in on that date. In an interview with the DOC, they acknowledged this.

Resident #003's plan of care did not include the planned care for the resident at the time they experienced a fall. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was based

on the needs and preferences of the resident.

According to CIS #2739-000005-20, submitted to the Director on an identified date in 2020, resident #002 deceased.

Resident #002's written plan of care indicated that they had an ongoing identified health diagnosis, but that they often refused assessment of this as well as refused care on a daily basis. A progress note written on an identified date in 2018 indicated that the resident had made a specific request regarding care.

In interviews with PSW's #108 and #110 and RPN's #106 and #109, all indicated that they were aware that the resident was only comfortable with a specific type of care provided. On an identified date in 2019, RPN #106 was unable to assess the resident so they implemented the specific request made by the resident a while back and was able to successfully assess the resident.

The resident's plan of care, which front line staff used to direct care, did not include the resident's preference for care, when possible.

In an interview with the DOC, they acknowledged that the resident's plan of care did not include this. The plan of care was not based on the preferences of the resident when it came to receiving care. [s. 6. (2)]

Issued on this 5th day of March, 2020

[redacted]

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

Original report signed by the inspector.