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

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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
Aug 9, 2018	2018_631210_0008	010645-17, 010784-17, 017815-17, 018807-17, 021499-17, 021685-17, 021806-17, 023146-17, 023154-17, 002075-18, 002166-18, 005295-18, 006424-18, 009167-18	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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

SLAVICA VUCKO (210), CECILIA FULTON (618), JULIENNE NGONLOGA (502)

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): April 25, 26, 27, 30, May 1, 2, 3, 4, 7, 8, 9, 10, 11, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Business Office Manager, Social Worker, Registered Nurses (RN), Nurse Consultant, Personal Support Workers (PSW), Environmental Services Manager, Maintenance Technician, Physiotherapist (PT), family members and residents.

During the course of this inspection, the inspector observed resident care, observed staff and resident interactions, reviewed resident health records and relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Review of Critical Incident System (CIS) report submitted to Ministry of Health and Long Term care (MOHLTC) on a specified date indicated that on a specified date resident #006 was observed demonstrating a responsive behavior towards co-resident #021 while they was sitting, resulting in a superficial body injury on resident #021's specific body parts. Resident #006 was noted to be upset.

Review of another CIS report submitted on a specified date, revealed that resident #006 demonstrated a responsive behaviour towards resident #019, which resulted in an injury. Prior to the incident, resident #006 threw an identified object at the assigned Personal Support Worker (PSW).

Review of resident #006's written plan of care completed on specified dates, under the focus responsive behaviour indicated responsive behaviours and directed the staff to implement identified interventions, when the resident exhibited the above mentioned responsive behaviours.

In separate interviews PSWs #116, #117, Registered Practical Nurses (RPNs) #114, and

#115 stated that resident likes specified duties and they will sit them in their room or another specific location and provide them with a specified activity to keep them occupied, and reduce the risk of altercation with resident #021. RPNs #114 and #115 further stated that this intervention was not included in resident #006's plan of care.

Nurse Consultant #119 acknowledged that if sitting resident #006 down and offering them a specified activity when staff are busy has been proven to be effective, staff should have included that in their written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Review of CIS report submitted to the MOHLTC on a specified date, revealed that on a specified date, resident #010 was found on the floor and had sustained an injury. The resident was transferred to hospital and diagnosed with a fracture and subsequently had a surgery.

According to the home's Falls Prevention Program revised in 2014, under the quality management section, a resident at level III, who attempts to get out of bed / chair unassisted, who is at high potential for injury, all interventions under level I, level II, and level III may be implemented as appropriate. This includes call bell, place all items needed by the resident within reach, maintain bed at lowest position, apply bed and chair sensors, establish bowel and bladder routine, hip protector and seating device.

According to the fall assessment completed upon admission, resident #010 was level III with a score of 12, which indicated that they were at high risk of fall.

Review of the progress notes and resident #010's written plan of care indicated that the resident should be monitored closely due to a previous fall which resulted in fractures.

On a specified date resident #010 had a fall at a specified location while trying to get up from a sitting position without assistance. The interventions put in place to minimize the risk of falls as mentioned above was to monitor the resident closely during the shift.

On another specified date resident #010 had a fall which resulted in a fracture of a body part and was transferred to the hospital.

In separate interviews RPN #107, Physiotherapist (PT) #102 and Registered Nurse (RN) #104 acknowledged that the intervention, monitor the resident closely, implemented on admission and after the first fall to reduce the risk of falls for resident #010, was not appropriate for the resident's risk level. They acknowledged that they should have considered other interventions including closely monitor the resident every 15 to 30 minutes, lower the bed, chair alarm, call bell within reach, toileting program, place all items needed by the resident within reach. [s. 6. (11) (b)]

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 has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the MOHLTC on a specified date that resident #001 complained to the home in writing that registered staff #109 answered them regarding their concern in an abusive way, on a specified date when other staff were around. RPN #110 was present during the conversation and resident stated that the conversation was overheard by Staff #111 who was passing by. Interview with Staff #111 did not confirm verbal or emotional abuse. The home completed an investigation, and abuse was not confirmed. The home responded to the resident on a specified date.

Interview with DOC #105 revealed the expectation is that every alleged incident of verbal or emotional abuse should be reported to the MOHLTC immediately and in this case it was reported three days after the home received the letter from the resident. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

A CIS report was submitted to the MOHLTC indicating that resident #005 complained to the home that on a specified date PSW #108 was rough during care.

A review of resident #005's clinical record revealed the resident was admitted to the home on a specified date with a fracture on an identified body part, for which had a particular treatment in place. According to the report and home's investigation notes, PSW #108 provided the indicated care, changed and repositioned them in bed alone. Interview with RN #104 revealed that resident #005 expressed to them that usually two staff reposition them in bed. The resident stated that after PSW #108 provided care to them as mentioned above, their pain level was worse than before. The inspector was not able to interview the resident because they were discharged.

A review of the written plan of care created at admission, under the section for dressing, bed mobility and continence care revealed interventions that the resident will receive assistance by staff for dressing, the resident will be able to move independently in bed by next review and the resident will be able to use the toilet by the next review. The care plan was updated at a later date indicating that the resident requires extensive assistance by two staff for toileting and no direction for bed mobility. On a later specified date, the section for dressing was updated that the resident will receive assistance by one staff.
An interview with DOC #105 revealed the written plan of care for residents should be created at admission and updated when there is a health status change.

Interview with DOC #105 acknowledged that the initial written plan of care for resident #005 did not give clear direction to PSWs how to provide personal care and the level of assistance during activities of daily living (ADLSs) such as dressing, bed mobility and continence care. [s. 26. (3) 7.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has to failed to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

Review of CIS report submitted to the MOHLTC on a specified date, revealed that on a specified date and time resident #008 was found lying in bed, incontinent of urine and bowel movement in their incontinence care product. According to the CIS, the resident verbalized that it has been happening every day.

Review of resident #008's written plan of care completed on a specified date, revealed that the resident required extensive assistance from one staff for transfer and toilet use. According to the plan of care under the focus of urinary incontinence resident #008 was frequently incontinent of bowel and bladder. The goal indicated that resident #008 will receive the appropriate support in changing continent care product to manage incontinence. The resident was to be prompted for toileting at specific time intervals during the day and night.

Review of Document Survey report for a specific month, indicated that during 19 nights staff did not document whether the assistance was provided to resident #008.

Review of the home investigation notes revealed that on a specified date the home was short staffed during an identified shift and the charge nurse assigned additional residents to each PSW present on the unit. PSW #112 was assigned two additional residents which included resident #008. According to the home's investigation notes resident #008 was not provided any care or assistance during the above mentioned identified shift. Review of a letter addressed to PSW #112 indicated that the PSW was no longer employed by the home.

The inspector was not able to interview PSW #112 and the interview data from the

home’s investigation was used.

According to the interview completed during the home’s investigation PSW #112 confirmed that resident #008 was assigned to them in addition to their regular resident assignment during the above mentioned identified shift and they did not provide any care or assistance to the resident as they had to complete other tasks in their regular assignment.

In an interview, DOC #105 stated that based on resident #008's concern and the home’s investigation the resident was not provided assistance with toileting. [s. 51. (2) (c)]

Issued on this 24th day of August, 2018

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

Original report signed by the inspector.