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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2020	2020_769646_0015	008477-20, 010564-20, 013009-20, 013626-20, 018215-20, 018334-20, 018949-20, 018950-20, 018951-20, 018952-20, 018953-20, 020451-20	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

Hawthorne Place Care Centre
2045 Finch Avenue West North York ON M3N 1M9

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

IVY LAM (646), IANA MOLOGUINA (763), JULIEANN HING (649)

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): October 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30, 2020.

Logs #008477-20 (CIS # 2586-000014-20), #013626-20 (follow-up inspection) related to falls prevention;
Log #010564-20 (CIS #2586-000015-20) and #020451-20 (CIS #2586-000032-20) related to staff to resident abuse;
Log #013009-20 (CIS #2586-000019-20) related to falls prevention;
Logs #018215-20 (follow-up inspection) and #018952-20 (follow-up inspection) related to infection prevention and control;
Log #018334-20 (follow-up inspection) related to residents' rights;
Log #018949-20 (follow-up inspection) related to nutrition and hydration;
Log #018950-20 (follow-up inspection) related to personal support services;
Log #018951-20 (follow-up inspection) related to transfers; and
Log #018953-20 (follow-up inspection) related to skin and wound.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Vice President (VP) of Operations, Nurse Clinician (NC), Assistant Director of Care (ADOC), Physician (MD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitians (RD), Food Service Manager (FSM), Dietary Aides, Admissions Coordinator, Quality Assurance Manager, Environmental Manager, Program Manager, Program Aides, Employee Engagement Specialist (EES), Social Worker, Residents, and Family Members.

The inspectors conducted observations of staff to resident interactions, resident observations, reviewed residents' clinical records, staffing schedules, home's compliance plan, home's training records, home's audits, and reviewed policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **4 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #002	2020_769646_0009	763
O.Reg 79/10 s. 229. (5)	CO #001	2020_769646_0007	763
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2020_769646_0010	646
O.Reg 79/10 s. 36.	CO #003	2020_769646_0009	649
O.Reg 79/10 s. 50. (2)	CO #004	2020_769646_0009	649
O.Reg 79/10 s. 87. (2)	CO #001	2020_754764_0008	763

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	Légende 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. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the order made under this Act.
A compliance order (CO) #004 was issued under inspection #2020_769646_0009 and made under O. Reg. 79/10, s. 50. (2) as follows:

The licensee must be compliant with O. Reg. 79/10, s. 50 (2).

Specifically, the licensee shall ensure that:
1) Skin and wound re-training is provided to registered staff working in the home for, but not limited to, the following:
a) The process for referral to a registered dietitian (RD) who is a member of the staff of the home, for assessment of a resident exhibiting altered skin integrity for the adequacy of nutrition and hydration, to promote wound healing.
b) A record is maintained for the training above, including the names and signatures of all registered staff who have been re-trained, the date the training was provided, the method of training provided, and the materials presented.
2) All PSWs and registered staff working in the home receive updated training on the following:
a) The definition of altered skin integrity, and what type of conditions should be reported and treated as altered skin integrity based on the home skin and wound care program.
b) A post-training evaluation is conducted to ensure comprehension of the education, and that the evaluation records are kept.
c) An auditing system is implemented to ensure that for any resident exhibiting altered skin integrity, the PSWs report and document the altered skin integrity and registered staff of the home provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevention. The auditing system should be conducted randomly for a period of three months following the service of this order.
3) Ensure that two specific residents, and any other resident with altered skin integrity who require assistance are provided turning and repositioning assistance as scheduled in the residents' plan of care.
4) An auditing system is developed in the home to ensure staff are assisting residents with turning and repositioning using safe techniques in accordance to each resident's plan of care.

At the time of the compliance due date, the home completed all steps except 2 (c).

The RPN who is the home's skin and wound lead, and the DOC both acknowledged that

step 2 (c) of the order was not completed.

Sources: Interviews with the home's skin and wound, Registered Practical Nurse (RPN) #100 and other staff. [s. 101. (3)]

2. CO # 003 was issued under inspection #2020_769646_0009 and made under O. Reg. 79/10, s. 36 as follows.

The licensee must be compliant with O. Reg. 79/10, s. 36.

The licensee must submit a plan to ensure that direct care staff are transferring residents with the recommended mechanical devices as specified in the residents' plans of care at all the times.
The plan shall include but not be limited to the following:

1) Completion of assessments of the proper slings required for each resident, and the record kept and available for PSWs and regular staff to check to determine which sling a resident requires.
2) Training/re-training for PSWs on safe transferring and positioning devices or techniques when assisting residents, including but not limited to how to assess and determine the proper sling required for each resident, and safe and proper use of slings for various kinds of lifts as required for the resident.
3) Maintain a written record of all education materials, including attendance sign in sheet.

4) Develop a plan to test and monitor staff knowledge and compliance on using safe transferring and positioning devices or techniques when assisting the residents.

At the time of the compliance due date, the home had not completed steps 2 and 4 of the order.

The home's training records indicated 71.9% of the PSWs did not complete the training. The inspector reviewed the training provided to the PSWs in the presence of a Registered Nurse (RN) who indicated they had not been provided training on how to identify the proper use of one type of transfer equipment for each resident as part of the training. Additionally, the home did not develop a plan to test and monitor staff knowledge. RN #115 acknowledged that steps 2 and 4 were not completed.

Sources: Interviews with RN #115, and other staff and review of the home's training

records including video training module. [s. 101. (3)]

3. As part of the condition of license, the licensee failed to comply with all the conditions outlined in order #001 issued under inspection #2020_769646_0007. The order required the licensee to do the following:

The licensee must be compliant with O. Reg 79/10, s. 229 (5).

Specifically, the licensee shall ensure that:
1) The residents' symptoms of infection are monitored every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
2) Staff on every shift record symptoms of infections and take immediate action as required;
3) Staff conduct audits of any residents on infection monitoring for exhibiting symptoms of infection; and
4) That a record of the training provided for staff is kept, and includes the dates the training(s) were held, names of staff who attended the training, and the dates and locations of the completed audits.

The grounds of the order indicated that staff failed to conduct twice daily active screening of all residents for fever, cough, or other symptoms of COVID-19, as required by "COVID-19 Directive #3 for Long-Term Care Homes" under the Long-Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7. The licensee also failed to ensure that staff took immediate action if a high temperature was identified. Several incidences of missing body temperatures as a result of low staffing levels in the home was included in the order grounds, as well as incidences of no action taken when a high body temperature was discovered.

Record review and staff interviews indicated that the home's previous Infection Prevention and Control (IPAC) lead conducted spot-check audits of all residents on infection monitoring a few times per week prior to the compliance due date of this order. However, the IPAC lead abruptly resigned and the home was unable to provide records of these audits. A new staff took over completing these audits, and provided a copy of an audit completed for symptom-monitoring of random residents during a 7-day period. The audit identified several residents whose temperatures were not monitored or documented, including:

- A resident who had missing infection symptom monitoring, and body temperature, on one evening shift, and
- Another resident who had missing infection symptom monitoring, and body temperature, on another evening shift.

Staff who missed the above symptom monitoring were interviewed and confirmed they forgot to complete active screening for the above residents. They were unable to recall whether symptom monitoring was completed but not recorded, or whether they forgot to monitor the resident's symptoms altogether.

Sources: the home's auditing records; PointClickCare (PCC) records for two residents, including assessments and progress notes; staff interviews: Nurse Clinician (NC) #115, RPN #140, Assistant Director of Care (ADOC) #144. [s. 101. (3)]

4. As part of the condition of license, the licensee failed to comply with all the conditions outlined in order #002 under inspection #2020_769646_0009. The order required the licensee to train and re-train all PSWs and registered staff working in the home on how to use the home's call bell system. It also directed the home to audit their call bell alarm history logs.

The grounds of the order indicated that staff were not using the home's communication response system effectively resulting in unanswered or delayed responses to resident calls. The home's established communication response system auditing process was lacking the ability to appropriately monitor the functionality of the calls bells, and call bell response time by staff.

A) The home's management team was aware of the training and re-training of staff on the use of the call bell system as per the order but did not complete this training by the compliance due date.

B) Call bell functionality audits were reviewed and did not indicate that the home audited call bell alarm history logs since order #002 was issued. The new Environmental Manager for the home and their trainee confirmed that no call bell alarm history log audits were completed since this order was issued, as they were both unaware of the need to do this until after the order was due. The home's Executive Director (ED) was also interviewed and confirmed it was the ED’s responsibility to ensure the management team was aware of their responsibilities about complying with issued orders from the MLTC, and that this was not done.

Sources: the home's call bell training records and call bell auditing records, staff interviews: NC, Environmental Manager, Quality Assurance Manager, ED. [s. 101. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 licensee complies with the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011's plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #011 was included as part of the resident sample for CO #001 from inspection #2020_769646_0009 related to lack of collaboration in the resident's enteral feed order.

Review of resident #011's Interdisciplinary Plan of Care (IDPC) showed that RD #114 had assessed the resident and ordered the resident to be provided a specific enteral feed at identified times.

Review of the resident's Electronic Medication Administration Record (eMAR) scheduled times showed that one of the administration times were different than what was ordered.

An RPN stated there was a discrepancy between resident #011's eMAR and the care plan for their enteral feed. The RPN further stated the computer likely automatically populated the time, and it had not been corrected on the eMAR since. The eMAR should be reviewed on quarterly assessment, and the registered staff who updates the care plan should review and update the eMAR.

The nurse clinician stated that the RD should have reviewed the eMAR during resident #011's assessment to correct the timing for the enteral feed and provide clear direction to the registered staff, but this was not done.

Sources: Resident #011's eMAR, Medication Admin Audit Report, Interdisciplinary Care Plan (IDPC) review, resident #011's care plan; interviews with RPN #107 and NC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #007's plan of care sets out clear directions to staff and others who provided direct care to the resident.

CO #001 related to lack of collaboration from inspection #2020_769646_0009 was issued to the licensee.

The licensee was ordered to ensure resident #007 and all other residents who received enteral feed in the home received an updated dietary assessment from the registered dietitian(s), to ensure that their prescribed enteral feed met their nutritional needs and was provided to them, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.

Resident #007's current care plan and eMAR showed the resident was ordered one type

of enteral feed, but if this was not available, staff were to provide a second type of enteral feed at the same rate; if neither were available, staff were to provide a third type of enteral feed at a lower rate. The eMAR also specified a water flush rate at one rate when using the first enteral feed; and at a higher rate when using the third enteral feed.

The current eMAR showed the water flush order for all three enteral feeds were cancelled, but the eMAR directions still included the three enteral formulas.

Resident #007's IDPC most recent review showed that the RD at the time had only prescribed the first enteral feed for the resident.

The RD at the time was no longer working in the home and was not aware of the compliance orders by the Ministry of Long-Term Care (MLTC), or that resident #007 was to be further assessed. The RD had assessed resident #007 as part of their routine assessment and saw that there were multiple enteral feeds on the eMAR order and the care plan, but no one had informed the RD that the resident's order needed clarification and the RD did not change the order.

The current stated they had recently started work in the home and had not assessed resident #007 until the management asked them to do so the week before the compliance order due date. The RD further stated the eMAR enteral feed order for resident #007 was unclear, as multiple enteral formulas were ordered for the resident. The RD stated the staff should inform the RD if an enteral feed was not available for the resident rather than substituting another formula for the resident. Two days after the compliance due date (CDD), the RD rewrote the order to only include one enteral formula for resident #007. The RD stated they were not aware of the details of the compliance orders or the CDD until several days before the due date.

An RPN stated the order was previously unclear as there were multiple formulas on the order. Upon review if the updated eMAR order, the RPN stated the directions of the eMAR still included three enteral formulas, but only include water flush direction for when the resident was on the first two enteral feed. The RPN stated this means the resident should be provided the same amount of water flush regardless of which enteral formula was used. However, the RPN was not aware that the previous order for the water flush for the resident was higher when using the third enteral feed. Therefore, the resident would have received less water if provided the third enteral feed if the staff followed the current direction from the resident's eMAR.

The lack of clear direction to the RDs about compliance order #001 puts resident #007 at risk of delayed assessment and correction to the enteral formula; the lack of clear direction to the registered staff puts the resident at risk of not receiving the proper nutrients they required.

The Director of Care (DOC) stated the enteral feed order needed further clarification and was not sure why the RDs were not informed about the details of the compliance order to assess resident #007, until approximately one and half months after the order was received.

Sources: Resident #007's eMAR, most recent IDPC, care plan, and progress notes; interviews with RDs, RN #123, and DOC. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of residents four residents, collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

CO #001 related to lack of collaboration from inspection #2020_769646_0009 was issued to the licensee.

The licensee was ordered to ensure that:
1) Three of the residents received an updated dietary assessment from the RD, to ensure the diet texture and fluid consistency was appropriate for the resident, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.
2) Three of the residents were provided the appropriate diet texture and fluid consistency as per the residents' care plans.
3) The fourth resident and all other residents who received enteral feed in the home received an updated dietary assessment from the RDs, to ensure that their prescribed enteral feed met their nutritional needs and was provided to them, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.
4) Food Service Manager (FSM), Food Service Supervisor (FSS), RDs, DOC, ADOCs, and appropriate registered staff members met to determine strategies for storage and provision of enteral formula to minimize the risk of coagulated enteral feeds, and that the

decision was communicated to the dietary staff and registered staff.
5) A record for actions taken with items #1, #3, and #4, was kept: including the date it was performed, the names of staff who attended, the content of discussion, issues identified and the follow-up actions taken.
6) An audit for item #2 was kept, including the date of the audit, the names of the residents, any issues identified, and resolution provided.

For item #1, two of the residents' dietary assessment showed they were completed before the order was issued, as part of the residents' IDPC review.

The fourth resident's dietary assessment showed was completed before the order was due, as part of their IDPC review.

For item #3, the resident's dietary assessments showed they were assessed before the order was issued, as part of the resident's IDPC review.

The RD at the time who completed the IDPC assessments for all four residents stated they had completed the assessments for the residents as part of their general practice, but was unaware of any orders issued to the licensee or the specific actions required as per the order. The RD stated they had stopped working in the home prior to the compliance order due date, and had not been involved in any discussions related to the orders issued to the home.

The RD at the time and the current RD stated they were not aware of content of the orders issued to the home until several days before the order was due. RD #114 stated they had not assessed the four residents prior to the compliance due date, as they were not the RD assigned to those residents.

The current RD who was the assigned RD for the four residents, stated they were unaware that those were residents of concern from the MLTC's orders issued to the home. The RD stated the DOC had informed them to provide education to the registered staff about the risk of enteral feeds during the week prior to the compliance due date, but the DOC was unable to provide the RD with details about what to educate the staff on, and the RD was unaware of the issue of coagulated enteral feed in the home.

The FSM stated they were not aware of the content of the orders for order #001 until four days after the compliance due date.

For item #4 of the order, observations of the enteral feed storage room on the unit showed one day of enteral feed for one resident, no enteral feed for a second resident, and four days of enteral feed for a third resident.

All three RDs and the FSM stated they were not involved in any meetings with each other or with the FSS, DOC, ADOCs, and registered staff to discuss strategies for storage and provision of enteral formula, to minimize the risk of coagulated enteral feeds, and had not provided communication of the above to the dietary and registered staff.

Three RPNs who worked in a unit that was on outbreak, stated the staff were directed to remain on the unit during their shift. They further stated that the information received in a memo from the DOC and the daily huddle was not consistent. They were informed there was a sign-off sheet in the dietary storage room that staff were to use when they obtain enteral feed and bring it to the unit for their resident. However, it was unclear how the staff can sign off if they are not able to leave the unit. The RPNs further stated it was unclear to them how much enteral feed should be kept on the unit for residents.

The DOC stated that a memo was provided to the registered staff regarding the storage and provision of enteral feed, which stated there should be seven days of enteral feed on the unit for each resident, and a two-week supply was to be available at any given time. However, the FSM stated they were not consulted on the directions until after the memo was issued, and that it was not feasible, as the kitchen currently stocks six to seven days of stock for each resident requiring enteral feed. Ten days after the compliance due date, the DOC stated the plan for item #4, the strategy for storage and provision enteral formulas to residents was still in progress.

For items #5 and #6 of the order, the RDs, FSMs, and DOC stated there was no discussion of issues identified or follow up actions taken for items #1, #3, and #4, and no audit was done regarding item #2.

The RDs were not made aware of the details of the compliance order until several days before the compliance due date and the FSM was not aware of the order until two days after the due date. There was a lack of collaboration between the home's management with the RDs and FSM, where the RDs were not informed of residents who required assessments as ordered by the MLTC and assessments were completed without knowledge of concerns identified from the MLTC inspection. The meetings, communications, follow-up, and audits were not completed as ordered for these residents, which puts the four residents above at risk that potential nutrition concerns

were neither identified nor addressed for these residents.

The lack of collaboration between the dietary and nursing staff in implementing a process of safe storage of enteral feed puts residents at risk of receiving enteral feeds that are not of optimal quality.

The NC and DOC stated the orders were discussed by the ED, DOC, quality lead, and the nursing team. They stated the RDs were not included in the meetings and could not specify who was to communicate the orders to the dietary department. They further stated there was no collaboration with the dietary department regarding the specifics of order #001 prior to the compliance due date.

Sources: Compliance order #001 from inspection #2020_769646_0009, Four residents' IDPC reviews and progress notes; observations of dietary and nursing storage of enteral feeds, observations of four residents; interviews with RDs, FSM, DOC, NC, and other staff members. [s. 6. (4)]

4. Please refer to the finding issued for resident #003 under resident #008. [s. 6. (4)]

5. Please refer to the finding issued for resident #004 under resident #008. [s. 6. (4)]

6. Please refer to the finding issued for resident #007 under resident #008. [s. 6. (4)]

7. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of resident #008's plan of care, so that the different aspects of care were integrated, consistent with and complemented each other.

This inspection was initiated to inspect CIS report #2586-000032-20 related to allegations of abuse from forcefeeding of the resident.

Review of the home's investigation notes showed the allegations of abuse had not been substantiated. Review of the resident's risk management notes of the incident showed the care plan was updated.

The BSO nurse had recommended that during feeding, the resident should be seated in an area that other residents are being fed by staff for close monitoring, due to behaviour of false accusation of force feeding.

The resident's care plan, revised after the BSO's recommendation by the DOC, showed two staff were to provide extensive assistance to the resident for eating. A later revision of the care plan by the DOC showed that the resident required one staff to provide extensive assistance with eating but two staff to be present during feeding. There was no documentation regarding the reason for change in the resident's eating intervention or any communication to staff.

Observation of the resident's room showed a memo posted above the head of bed, stating that they should be supervised by two staff at all times during feeding in their room.

Observation of the resident showed they either sat outside their room or in the dining room for meals; multiple observation at different meals showed there was only one staff providing eating assistance to the resident but a second staff member was not present when the resident was being fed.

One PSW and two RPNs stated that the resident required one staff to feed them at meals, but if the resident was fed in their room, two staff would be required. The PSW and RPNs stated this information was communicated to them by shift report and the memo posted in the resident's room and were aware this was put in place as the resident had made accusations of staff force-feeding them.

The staff stated the resident did not eat inside their room, and was always be fed by one staff, but there was no second staff present and looking at the resident when the resident is being fed.

They further stated it was not clear for them what two staff present at all times when resident was eating meant, as staff are busy with other residents during meals and it was not possible for two staff to be present the whole time. None of the staff members had raised their concerns with the managers regarding the feeding intervention for the resident, but continued to provide one-person feeding assistance.

A program staff stated they worked regularly with and had fed the resident but was not aware of any direction regarding two staff being present when feeding the resident.

The PSW and RPNs above stated they had not been asked for input and had not received information related to the level of feeding assistance as indicated at the daily

huddles. They followed the memo in the room, which did not apply, as the resident did not eat in their room.

The DOC stated that they had updated the intervention of two-person extensive feeding assistance in the resident's care plan in error, and had corrected it to two staff present at all times. The DOC stated they had put a memo in the resident's room which stated two staff to be present when the resident was in their room. The DOC had assumed that all residents ate breakfast in their rooms and was not aware that resident #008 had breakfast in the hallway. The DOC further stated none of the staff had informed them that the resident ate in the hallway, and that this information should have been in the resident's care plan. Their understanding of 'two-staff present at all times' meant two staff needed to be in the area and able to hear the resident while they are being fed at all times. The DOC stated they had not clarified for the staff what they meant, and that the memo in the resident's room did not have the same information as what was in the resident's care plan.

When the DOC developed an intervention to address the resident's responsive behaviours and allegation of abuse without collaborating with staff, and the staff did not communicate to the managers when the intervention put in place for the resident was both unclear and ineffective, there is risk that there was still no effective intervention developed or implemented to address the resident's behaviours and allegations of abuse.

The DOC stated that the home will continue to work on communication and collaboration.

Sources: Resident #008's progress notes, risk management notes, home's investigation notes; Observations of resident #008's bedroom, observations of resident #008 at mealtimes; interviews with PSW, RPNs, program staff, DOC, and other staff. [s. 6. (4) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that two PSWs and one RPN participated in the implementation of the home's infection prevention and control program (IPAC) when they failed to wear the required eye protection in resident common areas.

The home was in anoutbreak during the time of the inspection. Staff were instructed to follow droplet contact precautions on the third floor, including full PPE use when entering resident rooms to provide direct resident care. In addition, the home instructed all staff to wear eye protection and masks in all common areas of the home, as per the public health unit recommendations. Inspector #763 observed several incidences of staff not wearing eye protection appropriately during meal service on one floor:

- One was preparing meal trays for residents in the unit. The PSW was wearing their goggles on their forehead rather than over their eyes because they found it hard to see through the goggles. They also found the face shields were too big for their head and indicated that because of this, they found it difficult to wear eye protection in resident common areas.
- Another was serving meals to residents in their rooms while wearing their goggles on their forehead rather than over their eyes. They indicated that they knew eye protection was required but found it difficult to see through the goggles. The PSW adjusted the goggles over their eyes during the observation but the goggles only covered half of their eyes for the majority of the observation.

- An RPN was providing medication to residents on the home unit without wearing eye protection. They knew they were supposed to wear eye protection in all common areas and retrieved a new face shield from the nursing station after the inspector asked why they were not wearing their face shield.

Sources: staff interviews, observations of resident and staff interactions, email records.

Note: Order #005 under inspection #2020_769646_0009 will be re-issued as a result of this non-compliance. [s. 229. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that alleged abuse of resident #001 was immediately investigated.

The MLTC received a CIS report regarding alleged abuse of resident #001 by two staff members. The report indicated that the alleged abuse incident occurred. The home's investigation records indicated that the management team interviewed staff involved in the incident four days after the incident, and removed them from the work schedule pending results of the investigation on the same day. The home’s staffing records indicated that both staff continued to work in resident #001's unit for three days following the incident.

Both staff members confirmed their involvement in the incident and that they were sent home after being interviewed by the management team. An RN confirmed that they assisted with the investigation during interviews, but was not the person in charge of initiating the investigation; and was unsure why the incident was not investigated immediately after it occurred. The NC acknowledged that the investigation of this incident should have occurred immediately rather than three days after; the primary investigator was no longer working in the facility.

Sources: CIS report #2586-000015-20, home's investigation notes and staffing schedule, staff interviews. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the beverages was stored and served to resident #021 using methods that prevented foodborne illness.

While inspector #763 was observing meal tray service, a resident exited their room and indicated to the staff that the individual beverage that was served to them during the meal tasted foul. The beverage was sealed prior to being served to the resident and was within its expiration date. During the observation, it was also noted that the cart being used to serve residents' meals did not have adequate refrigeration for the dairy products available. A small freezing bin was available on the cart and did not have adequate space to hold the dairy product that was provided to residents during the meal service. In addition, the dairy alternative being used during the meal service was left on the cart outside of the freezer bin.

The resident was interviewed and noted that a few months prior, they were served another beverage which had coagulated and tasted foul. They stopped drinking that type of beverage due to this incident but started drinking it again more recently. On the day of the observation, they were served the beverage that tasted and smelled foul and asked the staff for another. Two more beverage cartons were provided, one of which smelled foul, so the resident threw it out. The third beverage smelled and tasted fresh, so they drank it. The resident guessed that when residents did not open or drink the individual beverages, staff collected the leftover beverages and brought them down to the kitchen to be reused at the next meal service. The resident indicated that trays full of uneaten food and fluids often sat in resident rooms for extended periods of time and were therefore at risk of spoiling.

The FSM indicated that they were aware of one previous incident of spoiled beverage a few months ago and thought it was because individual beverages were served to residents after the expiry date. Since that incident, they have been monitoring the expiry date of their dairy products, ensuring they were discarded by the indicated date. The

inspector explained to the FSM that the observed beverage carton was within its expiry date, indicating that the beverage likely spoiled due to storage issues. The FSM was then uncertain why the beverage spoiled, but indicated that the food service staff were expected to discard any remaining food and fluid items, whether opened or unopened, from the breakfast carts coming down from the home units, at the end of every meal service. They indicated that they had seen their staff doing this when they observed them clearing the meal carts. They acknowledged that the risk of spoilage was still possible given lack of refrigeration during breakfast service and the potential for items being reused while staff were not being monitored.

Sources: observations, staff and resident interviews. [s. 72. (3) (b)]

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 all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members' names who were present or involved in an incident of alleged abuse were included in the report of the incident to the Director.

The MLTC received a Critical Incident System (CIS) report regarding alleged staff to resident abuse. The report indicated only the initials of two staff members who were involved in the incident.

The NC confirmed that the CIS report did not name all staff members involved in the incident as required by the legislation and was unsure why. They indicated that they were aware that the home was expected to provide full names of staff members involved in the incident, and that a previous employee of the home submitted the report.

Sources: CIS report #2586-000015-20, staff interviews. [s. 104. (1) 2.]

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, in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's rights were fully respected, treated with courtesy and respect and transferred to their assistive mobility device for meals, to fully recognize the resident's individuality and respects their dignity.

The inspector observed the resident #005's transfer from the bed to the assistive mobility device. The resident told the inspector that their routine was to have meals in their assistive mobility device and go back to bed their meal. The resident explained that they were not able to have their meals on the above-mentioned date in their assistive mobility device because staff could not locate the a component of the lift for their transfer.

The resident told the inspector that they did not like having their meals in bed, and stated there was nothing they could do about it.

Sources: Observation of resident #005's transfer, interviews with resident and DOC. [s. 3. (1) 1.]

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

Issued on this 14th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646), IANA MOLOGUINA (763), JULIEANN HING (649)
Inspection No. / No de l'inspection :	2020_769646_0015
Log No. / No de registre :	008477-20, 010564-20, 013009-20, 013626-20, 018215-20, 018334-20, 018949-20, 018950-20, 018951-20, 018952-20, 018953-20, 020451-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 15, 2020
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, Markham, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, North York, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Sattler

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 101.(3)., related to O. Reg. 79/10, s. 36.

The licensee must ensure the following:
1) Retrain all PSWs on how to identify and utilize the proper sling size for each resident.
2) Implement an auditing tool to ensure PSWs are utilizing the correct sling size for resident's transfers.
3) Maintain a record of the training provided, including staff attendance records.
4) Maintain a written record of the auditing tool, to include the name of resident, date of the audit, names of staff audited, and outcome of the audit.

Grounds / Motifs :

1. CO # 003 was issued under inspection #2020_769646_0009 and made under O. Reg. 79/10, s. 36 as follows.

The licensee must be compliant with O. Reg. 79/10, s. 36.

The licensee must submit a plan to ensure that direct care staff are transferring residents with the recommended mechanical devices as specified in the residents' plans of care at all the times.
The plan shall include but not be limited to the following:

1) Completion of assessments of the proper slings required for each resident, and the record kept and available for PSWs and regular staff to check to

determine which sling a resident requires.
2) Training/re-training for PSWs on safe transferring and positioning devices or techniques when assisting residents, including but not limited to how to assess and determine the proper sling required for each resident, and safe and proper use of slings for various kinds of lifts as required for the resident.
3) Maintain a written record of all education materials, including attendance sign in sheet.
4) Develop a plan to test and monitor staff knowledge and compliance on using safe transferring and positioning devices or techniques when assisting the residents.

At the time of the compliance due date, the home had not completed steps 2 and 4 of the order.

The home's training records indicated 71.9% of the PSWs did not complete the training. The inspector reviewed the training provided to the PSWs in the presence of a Registered Nurse (RN) who indicated they had not been provided training on how to identify the proper use of one type of transfer equipment for each resident as part of the training. Additionally, the home did not develop a plan to test and monitor staff knowledge. RN #115 acknowledged that steps 2 and 4 were not completed.

Sources: Interviews with RN #115, and other staff and review of the home's training records including video training module.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm because the staff did not receive the training and auditing of proper identification and use of slings as ordered.
Scope: Out of ten follow-up orders, the licensee had not fully complied with four.
Compliance History: In the past 36 months, the licensee was found to be non-compliant with LTCHA 2007 S.O. 2007, c.8, s.101.(3), and two voluntary plans of correction (VPC), and one compliance orders (CO) were issued. (649)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 12, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.(1).

Specifically, the licensee must:
1) Ensure that this order is communicated to the registered dietitian(s).
2) Ensure that residents #007 and #011's enteral feed orders are assessed by the registered dietitian(s).
3) Ensure that residents #007 and #011's care plans, including their eMAR, are reviewed and the rate and times of the enteral feeds and water flushes are clearly written to reflect the assessment in #2.
4) Ensure that: a) Residents #007 and #011's enteral feed and water flush orders are clearly communicated to the registered staff working with the residents, and
b) Audits are completed to ensure residents #007 and #011's are receiving the correct formula, at the correct rate and correct water flushes as ordered.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #011's plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #011 was included as part of the resident sample for CO #001 from inspection #2020_769646_0009 related to lack of collaboration in the resident's enteral feed order.

Review of resident #011's Interdisciplinary Plan of Care (IDPC) showed that RD

#114 had assessed the resident and ordered the resident to be provided a specific enteral feed at identified times.

Review of the resident's Electronic Medication Administration Record (eMAR) scheduled times showed that one of the administration times were different than what was ordered.

An RPN stated there was a discrepancy between resident #011's eMAR and the care plan for their enteral feed. The RPN further stated the computer likely automatically populated the time, and it had not been corrected on the eMAR since. The eMAR should be reviewed on quarterly assessment, and the registered staff who updates the care plan should review and update the eMAR.

The nurse clinician stated that the RD should have reviewed the eMAR during resident #011's assessment to correct the timing for the enteral feed and provide clear direction to the registered staff, but this was not done.

Sources: Resident #011's eMAR, Medication Admin Audit Report, Interdisciplinary Care Plan (IDPC) review, resident #011's care plan; interviews with RPN #107 and NC. (646)

2. The licensee has failed to ensure that resident #007's plan of care sets out clear directions to staff and others who provided direct care to the resident.

CO #001 related to lack of collaboration from inspection #2020_769646_0009 was issued to the licensee.

The licensee was ordered to ensure resident #007 and all other residents who received enteral feed in the home received an updated dietary assessment from the registered dietitian(s), to ensure that their prescribed enteral feed met their nutritional needs and was provided to them, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.

Resident #007's current care plan and eMAR showed the resident was ordered one type of enteral feed, but if this was not available, staff were to provide a second type of enteral feed at the same rate; if neither were available, staff were

to provide a third type of enteral feed at a lower rate. The eMAR also specified a water flush rate at one rate when using the first enteral feed; and at a higher rate when using the third enteral feed.

The current eMAR showed the water flush order for all three enteral feeds were cancelled, but the eMAR directions still included the three enteral formulas.

Resident #007's IDPC most recent review showed that the RD at the time had only prescribed the first enteral feed for the resident.

The RD at the time was no longer working in the home and was not aware of the compliance orders by the Ministry of Long-Term Care (MLTC), or that resident #007 was to be further assessed. The RD had assessed resident #007 as part of their routine assessment and saw that there were multiple enteral feeds on the eMAR order and the care plan, but no one had informed the RD that the resident's order needed clarification and the RD did not change the order.

The current stated they had recently started work in the home and had not assessed resident #007 until the management asked them to do so the week before the compliance order due date. The RD further stated the eMAR enteral feed order for resident #007 was unclear, as multiple enteral formulas were ordered for the resident. The RD stated the staff should inform the RD if an enteral feed was not available for the resident rather than substituting another formula for the resident. Two days after the compliance due date (CDD), the RD rewrote the order to only include one enteral formula for resident #007. The RD stated they were not aware of the details of the compliance orders or the CDD until several days before the due date.

An RPN stated the order was previously unclear as there were multiple formulas on the order. Upon review if the updated eMAR order, the RPN stated the directions of the eMAR still included three enteral formulas, but only include water flush direction for when the resident was on the first two enteral feed. The RPN stated this means the resident should be provided the same amount of water flush regardless of which enteral formula was used. However, the RPN was not aware that the previous order for the water flush for the resident was higher when using the third enteral feed. Therefore, the resident would have received less water if provided the third enteral feed if the staff followed the

current direction from the resident's eMAR.

The lack of clear direction to the RDs about compliance order #001 puts resident #007 at risk of delayed assessment and correction to the enteral formula; the lack of clear direction to the registered staff puts the resident at risk of not receiving the proper nutrients they required.

The Director of Care (DOC) stated the enteral feed order needed further clarification and was not sure why the RDs were not informed about the details of the compliance order to assess resident #007, until approximately one and half months after the order was received.

Sources: Resident #007's eMAR, most recent IDPC, care plan, and progress notes; interviews with RDs, RN #123, and DOC.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm to residents #007 and #011 because of the lack of clear direction to staff for the residents' enteral feeds
Scope: Out of the three residents reviewed, two residents were affected.
Compliance History: In the past 36 months, the licensee was found to be non-compliant with LTCHA s. 6.(1), and two voluntary plans of correction (VPC), and two written notices (WN) were issued. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 12, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_769646_0009, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.(4).

Specifically, the licensee must:
1) Ensure that this order is communicated to the relevant staff and managers, including the Director of Care (DOC), Assistant DOC(s), registered dietitian(s), food service manager and food service supervisor.
2) Ensure that the staff above collaborate to develop and implement strategies for storage and provision of enteral formula to minimize the risk of coagulated enteral feeds, and that the decision is communicated to the dietary staff and registered staff.
3) An audit for item #2 is kept, including the date of the audit, the names of the residents, any issues identified, and action taken.
4) The eating assistance and responsive behaviour care plan for resident #008 is reviewed and revised in collaboration with input from the PSWs and registered staff working with the resident, to ensure the care is appropriate for and is provided for the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of residents four residents, collaborated with each other

in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

CO #001 related to lack of collaboration from inspection #2020_769646_0009 was issued to the licensee.

The licensee was ordered to ensure that:
1) Three of the residents received an updated dietary assessment from the RD, to ensure the diet texture and fluid consistency was appropriate for the resident, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.
2) Three of the residents were provided the appropriate diet texture and fluid consistency as per the residents' care plans.
3) The fourth resident and all other residents who received enteral feed in the home received an updated dietary assessment from the RDs, to ensure that their prescribed enteral feed met their nutritional needs and was provided to them, and that the assessment results were communicated to the registered staff and PSWs who worked with the residents.
4) Food Service Manager (FSM), Food Service Supervisor (FSS), RDs, DOC, ADOCs, and appropriate registered staff members met to determine strategies for storage and provision of enteral formula to minimize the risk of coagulated enteral feeds, and that the decision was communicated to the dietary staff and registered staff.
5) A record for actions taken with items #1, #3, and #4, was kept: including the date it was performed, the names of staff who attended, the content of discussion, issues identified and the follow-up actions taken.
6) An audit for item #2 was kept, including the date of the audit, the names of the residents, any issues identified, and resolution provided.

For item #1, two of the residents' dietary assessment showed they were completed before the order was issued, as part of the residents' IDPC review.

The fourth resident's dietary assessment showed was completed before the order was due, as part of their IDPC review.

For item #3, the resident's dietary assessments showed they were assessed before the order was issued, as part of the resident's IDPC review.

The RD at the time who completed the IDPC assessments for all four residents stated they had completed the assessments for the residents as part of their general practice, but was unaware of any orders issued to the licensee or the specific actions required as per the order. The RD stated they had stopped working in the home prior to the compliance order due date, and had not been involved in any discussions related to the orders issued to the home.

The RD at the time and the current RD stated they were not aware of content of the orders issued to the home until several days before the order was due. RD #114 stated they had not assessed the four residents prior to the compliance due date, as they were not the RD assigned to those residents.

The current RD who was the assigned RD for the four residents, stated they were unaware that those were residents of concern from the MLTC's orders issued to the home. The RD stated the DOC had informed them to provide education to the registered staff about the risk of enteral feeds during the week prior to the compliance due date, but the DOC was unable to provide the RD with details about what to educate the staff on, and the RD was unaware of the issue of coagulated enteral feed in the home.

The FSM stated they were not aware of the content of the orders for order #001 until four days after the compliance due date.

For item #4 of the order, observations of the enteral feed storage room on the unit showed one day of enteral feed for one resident, no enteral feed for a second resident, and four days of enteral feed for a third resident.

All three RDs and the FSM stated they were not involved in any meetings with each other or with the FSS, DOC, ADOCs, and registered staff to discuss strategies for storage and provision of enteral formula, to minimize the risk of coagulated enteral feeds, and had not provided communication of the above to the dietary and registered staff.

Three RPNs who worked in a unit that was on outbreak, stated the staff were

directed to remain on the unit during their shift. They further stated that the information received in a memo from the DOC and the daily huddle was not consistent. They were informed there was a sign-off sheet in the dietary storage room that staff were to use when they obtain enteral feed and bring it to the unit for their resident. However, it was unclear how the staff can sign off if they are not able to leave the unit. The RPNs further stated it was unclear to them how much enteral feed should be kept on the unit for residents.

The DOC stated that a memo was provided to the registered staff regarding the storage and provision of enteral feed, which stated there should be seven days of enteral feed on the unit for each resident, and a two-week supply was to be available at any given time. However, the FSM stated they were not consulted on the directions until after the memo was issued, and that it was not feasible, as the kitchen currently stocks six to seven days of stock for each resident requiring enteral feed. Ten days after the compliance due date, the DOC stated the plan for item #4, the strategy for storage and provision enteral formulas to residents was still in progress.

For items #5 and #6 of the order, the RDs, FSMs, and DOC stated there was no discussion of issues identified or follow up actions taken for items #1, #3, and #4, and no audit was done regarding item #2.

The RDs were not made aware of the details of the compliance order until several days before the compliance due date and the FSM was not aware of the order until two days after the due date. There was a lack of collaboration between the home's management with the RDs and FSM, where the RDs were not informed of residents who required assessments as ordered by the MLTC and assessments were completed without knowledge of concerns identified from the MLTC inspection. The meetings, communications, follow-up, and audits were not completed as ordered for these residents, which puts the four residents above at risk that potential nutrition concerns were neither identified nor addressed for these residents.

The lack of collaboration between the dietary and nursing staff in implementing a process of safe storage of enteral feed puts residents at risk of receiving enteral feeds that are not of optimal quality.

The NC and DOC stated the orders were discussed by the ED, DOC, quality lead, and the nursing team. They stated the RDs were not included in the meetings and could not specify who was to communicate the orders to the dietary department. They further stated there was no collaboration with the dietary department regarding the specifics of order #001 prior to the compliance due date.

Sources: Compliance order #001 from inspection #2020_769646_0009, Four residents' IDPC reviews and progress notes; observations of dietary and nursing storage of enteral feeds, observations of four residents; interviews with RDs, FSM, DOC, NC, and other staff members. (646)

2. Please refer to the finding issued for resident #003 under resident #008. (646)

3. Please refer to the finding issued for resident #004 under resident #008. (646)

4. Please refer to the finding issued for resident #007 under resident #008. (646)

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of resident #008's plan of care, so that the different aspects of care were integrated, consistent with and complemented each other.

This inspection was initiated to inspect CIS report #2586-000032-20 related to allegations of abuse from forcefeeding of the resident.

Review of the home's investigation notes showed the allegations of abuse had not been substantiated. Review of the resident's risk management notes of the incident showed the care plan was updated.

The BSO nurse had recommended that during feeding, the resident should be seated in an area that other residents are being fed by staff for close monitoring, due to behaviour of false accusation of force feeding.

The resident's care plan, revised after the BSO's recommendation by the DOC, showed two staff were to provide extensive assistance to the resident for eating. A later revision of the care plan by the DOC showed that the resident required

one staff to provide extensive assistance with eating but two staff to be present during feeding. There was no documentation regarding the reason for change in the resident's eating intervention or any communication to staff.

Observation of the resident's room showed a memo posted above the head of bed, stating that they should be supervised by two staff at all times during feeding in their room.

Observation of the resident showed they either sat outside their room or in the dining room for meals; multiple observation at different meals showed there was only one staff providing eating assistance to the resident but a second staff member was not present when the resident was being fed.

One PSW and two RPNs stated that the resident required one staff to feed them at meals, but if the resident was fed in their room, two staff would be required. The PSW and RPNs stated this information was communicated to them by shift report and the memo posted in the resident's room and were aware this was put in place as the resident had made accusations of staff force-feeding them.

The staff stated the resident did not eat inside their room, and was always be fed by one staff, but there was no second staff present and looking at the resident when the resident is being fed.

They further stated it was not clear for them what two staff present at all times when resident was eating meant, as staff are busy with other residents during meals and it was not possible for two staff to be present the whole time. None of the staff members had raised their concerns with the managers regarding the feeding intervention for the resident, but continued to provide one-person feeding assistance.

A program staff stated they worked regularly with and had fed the resident but was not aware of any direction regarding two staff being present when feeding the resident.

The PSW and RPNs above stated they had not been asked for input and had not received information related to the level of feeding assistance as indicated at the daily huddles. They followed the memo in the room, which did not apply, as

the resident did not eat in their room.

The DOC stated that they had updated the intervention of two-person extensive feeding assistance in the resident's care plan in error, and had corrected it to two staff present at all times. The DOC stated they had put a memo in the resident's room which stated two staff to be present when the resident was in their room. The DOC had assumed that all residents ate breakfast in their rooms and was not aware that resident #008 had breakfast in the hallway. The DOC further stated none of the staff had informed them that the resident ate in the hallway, and that this information should have been in the resident's care plan. Their understanding of 'two-staff present at all times' meant two staff needed to be in the area and able to hear the resident while they are being fed at all times. The DOC stated they had not clarified for the staff what they meant, and that the memo in the resident's room did not have the same information as what was in the resident's care plan.

When the DOC developed an intervention to address the resident's responsive behaviours and allegation of abuse without collaborating with staff, and the staff did not communicate to the managers when the intervention put in place for the resident was both unclear and ineffective, there is risk that there was still no effective intervention developed or implemented to address the resident's behaviours and allegations of abuse.

The DOC stated that the home will continue to work on communication and collaboration.

Sources: Resident #008's progress notes, risk management notes, home's investigation notes; Observations of resident #008's bedroom, observations of resident #008 at mealtimes; interviews with PSW, RPNs, program staff, DOC, and other staff.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm to residents #003, #004, #007, and #008 related to lack of collaboration in the assessments, development, and implementation of the residents' plans of care.
Scope: Out of the four residents reviewed, lack of collaboration was identified for all four residents.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Compliance History: In the past 36 months, the licensee was found to be non-compliant with LTCHA s. 6.(4), and three compliance orders (CO) were issued. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 12, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_769646_0009, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must comply with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:
1) Review direct care staff feedback on current challenges with PPE use in the home, and approaches to increase adherence to using PPE appropriately. Ensure the feedback is documented.
2) Perform audits of PPE use four times per week on various home areas, to ensure staff are using the appropriate PPE when indicated and according to the home's established plan.
3) Document the audits, provide on-the-spot re-education, and continue auditing for three months or until no further concerns arise with the use of PPE by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that two PSWs and one RPN participated in the implementation of the home's infection prevention and control program (IPAC) when they failed to wear the required eye protection in resident common areas.

The home was in anoutbreak during the time of the inspection. Staff were instructed to follow droplet contact precautions on the third floor, including full PPE use when entering resident rooms to provide direct resident care. In addition, the home instructed all staff to wear eye protection and masks in all common areas of the home, as per the public health unit recommendations. Inspector #763 observed several incidences of staff not wearing eye protection appropriately during meal service on one floor:

- One was preparing meal trays for residents in the unit. The PSW was wearing their goggles on their forehead rather than over their eyes because they found it hard to see through the goggles. They also found the face shields were too big for their head and indicated that because of this, they found it difficult to wear eye protection in resident common areas.
- Another was serving meals to residents in their rooms while wearing their goggles on their forehead rather than over their eyes. They indicated that they knew eye protection was required but found it difficult to see through the goggles. The PSW adjusted the goggles over their eyes during the observation but the goggles only covered half of their eyes for the majority of the observation.

- An RPN was providing medication to residents on the home unit without wearing eye protection. They knew they were supposed to wear eye protection in all common areas and retrieved a new face shield from the nursing station after the inspector asked why they were not wearing their face shield.

Sources: staff interviews, observations of resident and staff interactions, email records.

Note: Order #005 under inspection #2020_769646_0009 will be re-issued as a result of this non-compliance.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to residents as a result of inappropriate use of eye protection by staff.
Scope: The scope was widespread because all three staff reviewed did not use PPE appropriately.
Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #005 was issued on August 26, 2020 (inspection #2020_769646_0009) with a compliance due date of October 19, 2020. In the past 36 months, 11 other COs were issued to different sections of the legislation, all of which have been complied, and one other CO was re-issued. (763)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 12, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

Service Area Office /
Bureau régional de services : Toronto Service Area Office