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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_349590_0024	027413-16	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

BANWELL GARDENS
3000 BANWELL ROAD P. O. BOX 3246 TECUMSEH ON N8N 2M4

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), SANDRA FYSH (190), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 13 - 16, 19 - 23 & 26, 2016.

The following Critical Incidents were inspected concurrently during this RQI:

CIS #2263-000047-15/LSAO Log #034721-15 was related to responsive behaviours.
CIS #2263-000002-16/LSAO Log #001067-16 was related to responsive behahviours.

CIS #2263-000008-16/LSAO Log #008781-16 was related to alleged abuse.
CIS #2263-000026-16/LSAO Log #017488-16 was related to falls prevention.
CIS #2263-000032-16/LSAO Log #020353-16 was related to alleged abuse and responsive behaviours.
CIS #2263-000041-16/LSAO Log #026534-16 was related to alleged abuse and responsive behaviours.

The following Complaints were inspected concurrently during this RQI:

IL-43216-LO/LSAO Log #007404-16 was related to care concerns for a specific resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Environmental Services Manager, the Activity/Restorative Care Manager, the Dietary Manager, the Manager of Clinical Informatics, the Registered Dietitian (RD), five Registered Nurses (RN), eight Registered Practical Nurses (RPN), 11 Personal Support Workers (PSW), one Physiotherapy Assistant, one Restorative Aide, the President of the Resident's Council, the President of the Family Council, two Family Members, one Personal Care Aide and 40+ Residents.

During the course of the inspection, the inspector(s) observed all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions and infection prevention and control practices.

During the course of the inspection, the inspector(s) reviewed resident clinical records, posting of required information, meeting minutes of the Resident and Family Council, Critical Incident Reports and relevant policies and procedures related to inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #039 required specifically timed medications from staff throughout the day. On September 20, 2016, resident #039 was observed receiving medication at a specified time in their room, approximately an hour after the medication was due to be given.
The physician orders for resident #039 stated that medication was to be provided at specified times, three times a day.
Resident #039's most recent care plan indicated that medication was to be given at the specified times throughout the day, as identified by the Physician.

Resident #040 required specifically timed medications from staff throughout the day. On September 20, 2016, resident #040 was observed receiving medication at a specified time in their room, approximately an hour after the medication was due to be given.
The physician orders for resident #040 stated that medication was to be provided at specified times, three times a day.
Resident #040's most recent care plan indicated that medication was to be given at the specified times throughout the day, as identified by the Physician.

Interviews with RPN #117, #119 and #120 explained the routine medication timelines unless specifically ordered by a physician, and if for some reason the medication could not be given as ordered by the physician, a charge nurse should be approached and the physician should be notified for clarification of the order.

The DON #116 confirmed that the expectation was that medication be administered to residents in accordance with the directions for use specified by the prescriber.

The scope of this non-compliance was determined to be a pattern as this occurred twice in one medication administration pass. The severity of this non-compliance was determined by the fact that this practise could cause minimal harm or has the potential to cause actual harm to residents. The home does not have a compliance history related to this area of legislation and was classified as having previous non-related non-compliance. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Resident #052 was observed to have one bed rail in the up position on the bed. According to the "Interdisciplinary Restraint Assessment and Consent" form, the bed rails were used for safety, positioning and comfort.

The inspector was unable to locate a completed assessment in the resident's clinical record that would provide information related to why the resident needs to use the bed rails, what type of bed rails should be used and when they should be used.

Review of the home's policy titled "Bed Rails", Index I.D: RCS E-05 and last revised on July 15, 2015, revealed the following requirements are to be completed:

"Use of a bed rail should be based on the resident's assessed medical needs and should be documented clearly and approved by the interdisciplinary team."

"The resident's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they previously attempted and determined not to be the treatment of choice for the resident."
"On admission all resident's are assessed for the need of raised bed rails. This interdisciplinary assessment could indicate two bed rails raised, one bed rail raised or no bed rails are needed."
"Documentation of the risk-benefit assessment should be made in the form of a progress note in the resident's electronic health record."

Interview with the Manager of Clinical Informatics #103 revealed that on admission residents were to have a progress note made which would include the information mentioned above and that the care plan should also include this information for direct care staff.

In an interview with the Administrator #102 she confirmed that there had not been a progress note entry completed on admission and there had not been an assessment completed either. The Administrator shared that the home's expectations were that staff were to complete an admission progress note related to bed rails and that an assessment was to be documented using the "Least Restraint Form". [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Resident #003 was observed to have bed rails in the up position on the bed. According to the "Interdisciplinary Restraint Assessment and Consent" form, the bed rails were used for safety, positioning and comfort.

The inspector was unable to locate a completed assessment in the resident's clinical record that would provide information related to why the resident needs to use the bed rails, what type of bed rails should be used and when they should be used.

Review of the home's policy titled "Bed Rails", Index I.D: RCS E-05 and last revised on July 15, 2015 revealed the following requirements are to be completed:

"Use of a bed rail should be based on the resident's assessed medical needs and should be documented clearly and approved by the interdisciplinary team."

"The resident's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they previously attempted and determined not to be the treatment of choice for the resident."
"On admission all resident's are assessed for the need of raised bed rails. This interdisciplinary assessment could indicate two bed rails raised, one bed rail raised or no bed rails are needed."
"Documentation of the risk-benefit assessment should be made in the form of a progress note in the resident's electronic health record."

Interview with the Manager of Clinical Informatics #103 revealed that on admission residents were to have a progress note made which would include the information mentioned above and that the care plan should also include this information for direct care staff. [s. 15. (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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

On September 21, 2016, at 1400 hours Inspector #190 observed an unlabeled clear ziplock bag containing approximately 75 - 100 unlabeled capsules in a pulled out drawer at the nursing station. When asked, the RN at the desk was unaware of where the capsules came from, what they were or whose they were and proceeded to secure them in a locked cupboard below the drawer.

Inspector #590 approached the Administrator #100 and we went and observed the capsules together, which were immediately provided to and removed from the desk by the Administrator. The Administrator shared that she was unaware of this situation and would be completing a full investigation into the capsules. She confirmed the homes expectation that all medications were to labeled and stored properly according to the home's policies. [s. 122. (1)]

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 no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario, to be implemented voluntarily.

Issued on this 5th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), ALISON FALKINGHAM (518), SANDRA FYSH (190), TERRI DALY (115)
Inspection No. / No de l'inspection :	2016_349590_0024
Log No. / Registre no:	027413-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 3, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	BANWELL GARDENS 3000 BANWELL ROAD, P. O. BOX 3246, TECUMSEH, ON, N8N-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya Adams

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 Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that resident #039, resident #040 and all other residents prescribed to receive a specific medication are administered the medication in accordance with the time specified by the Physician.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #039 required specifically timed medications from staff throughout the day. On September 20, 2016, resident #039 was observed receiving medication at a specified time in their room, approximately an hour after the medication was due to be given.
The physician orders for resident #039 stated that medication was to be provided at specified times, three times a day.
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The physician orders for resident #040 stated that medication was to be provided at specified times, three times a day.
Resident #040's most recent care plan indicated that medication was to be given at the specified times throughout the day, as identified by the Physician.

Interviews with RPN #117, #119 and #120 explained the routine medication

timelines unless specifically ordered by a physician, and if for some reason the medication could not be given as ordered by the physician, a charge nurse should be approached and the physician should be notified for clarification of the order.

The DON #116 confirmed that the expectation was that medication be administered to residents in accordance with the directions for use specified by the prescriber.

The scope of this non-compliance was determined to be a pattern as this occurred twice in one medication administration pass. The severity of this non-compliance was determined by the fact that this practise could cause minimal harm or has the potential to cause actual harm to residents. The home does not have a compliance history related to this area of legislation and was classified as having previous non-related non-compliance. [s. 131. (2)]
(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 06, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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