Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2018	2018_563670_0002	028913-17	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

DEBRA CHURCHER (670), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18 and 19, 2018.

The following complaints were inspected during this Resident Quality Inspection:
Log #015374-17 Infoline #51806-LO related to alleged improper care.
Log #028932-17 Infoline #54591-LO related to alleged financial abuse.
Log #027278-17 Infoline #54327-LO related to alleged misappropriation of a resident's property.

The following follow up to Orders of the Inspector was completed during this RQI:
Log #029559-16 Follow up to order #001 from RQI #2016_349590_0024.

The following Critical Incident System (CIS) reports were inspected during this RQI:
Log #014933-17 CIS #2262-000048-17 related to alleged abuse.
Log # 014053-17 CIS #2263-000045-17 related to alleged abuse.
Log # 016519-17 CIS #2263-000052-17 related to alleged abuse.
Log #026414-17 CIS #2263-000068-17 related to alleged abuse.
Log #024028-17 CIS #2263-000062-17 related to alleged abuse.
Log #023307-17 CIS #2263-000059-17 related to alleged abuse.
Log #001226-18 CIS #2263-000005-18 related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, Residents' Council representative, Family Council representative, the Administrator, The Director of Care, the Assistant Director of Care, the Clinical Coordinator, the Resident Assessment Instrument Coordinator, the Programs and Restorative Manager, the Nurse Clinician, the Behavioral Supports Ontario Personal Support Worker, the Behavioral Supports Ontario Registered Practical Nurse, five family members, seven Personal Support Workers, four Registered Practical Nurses and one Registered Nurse.

During the course of the inspection, the Inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records and the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **3 WN(s)**
- **2 VPC(s)**
- **0 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. 131. (2)	CO #001	2016_349590_0024	670

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available at each shower location used by residents.

During the initial tour of the home's Resident Quality Inspection, two shower stalls were observed located within the bathing room in the corridor identified as "600". There was no call bell available within the vicinity of the two shower stalls.

A Personal Support Worker (PSW) observed the area and stated that there were no call bells accessible in the shower stalls. The PSW stated that the shower stalls in the 600 bathing room were currently being used by residents for showering.

The Administrator stated that it was the expectation that the resident-staff communication and response system was available at each shower location used by residents [s. 17. (1) (d)]

2. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the initial tour of the home's Resident Quality Inspection, it was noted that the following home areas were not equipped with a resident-staff communication and response system: the home's hair salon, main foyer sitting area (with television), outdoor courtyard, a lounge area near the courtyard across from the charge nurse desk, the Rose dining room and the physiotherapy room.

The Administrator toured these areas with Inspector #537 and stated that the areas were accessible to residents and call bells were not available in these areas, that there were plans and renovations currently taking place to install call bells, but that the work had not been completed yet. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed, toilet, bath and shower location used by residents and is available in every area accessible by residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home had submitted a Critical Incident System (CIS) report, to the Ministry of Health and Long-Term Care, on a specific date, which identified potential staff to resident abuse, as reported by a specific resident and then subsequently verified by the family of the specific resident.

On January 18, 2018, the Administrator was interviewed and stated to Inspector #537 that they commenced an internal investigation into the allegations. The Administrator interviewed a specific resident, who reported specific events. The Administrator stated to Inspector #537 that while interviewing the specific resident regarding the allegations the specific resident shared that there had been additional incidents. As a result of this information that was provided during the investigation, the Administrator contacted the family of the specific resident, and was told by the family of the specific resident that they were aware of the incidents.

On January 18, 2018, a specific resident was interviewed in their room and was able to

recount the reported incidents.

Interview was conducted with a specific Personal Support Worker (PSW), who indicated that they were no longer employed by the home. The PSW acknowledged the reported incidents.

The Administrator stated that the actions of the identified PSW were considered to be a specific type of abuse and that the specific resident had not been protected from the specific type of abuse. The Administrator stated that they had terminated the specific PSW related to the specific incidents.

2. The home's policy titled "Abuse and Neglect Policy" last revised July 2015, stated "The abuse or neglect of a Resident will not be tolerated by the Home."

A review of clinical records, related to four Critical Incident System reports revealed that a specific resident had been admitted to the home on a specific date, with a specific diagnosis.

Interview and review of the specific resident's clinical record was completed with a Registered Practical Nurse Behavioral Support Ontario (RPNBSO) who provided a summary of incidents from a specific period of time, which revealed four critical incidents reported to the Ministry of Health and Long-Term Care Critical Incident System. There were two additional incidents that did not meet the reporting requirements, and thirteen incidents of a specific action, by a specific resident, directed at care staff.

Geriatric Mental Health Outreach Team (GMHOT) consult dated for a specific date documented specific risks that a specific resident presented to other specific residents.

Interview with a Support Worker Behavioral Supports Ontario (PSWBSO), who stated that the specific resident had been followed by external care partners since a specific date. The PSWBSO stated that after there were specific interventions in place for the specific resident and the interventions would be changed and additional interventions would be added with any additional incidents. PSWBSO stated that the interventions had been ineffective.

January 17, 2018, in the presence of Inspector #670 and Inspector #537, the Director of Care (Director of Care) stated that they were aware that the GMHOT consult had listed

the resident as a specific risk for specific residents and stated that they did what they could to protect the residents.

January 18, 2018, in the presence of Inspector #670 and Inspector #537, the Administrator acknowledged that the specific resident continued to have specific incidents every few months and that specific external and internal supports were working with the resident and interventions were in place. The Administrator stated that they had done what they could with the resources available to them as they had additional residents that had similar issues that required significant resources. [s. 19. (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 the licensee will protect residents from abuse by anyone and will ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy, was complied with.

Ontario Regulation 68 (2) (a) related to nutrition care and hydration programs, states, "Every licensee of a long-term care home shall ensure that the programs include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration."

Ontario Regulation 68 (e) ii states, that the program includes "a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter."

During stage one of the RQI Inspector #670 noted that a total of three residents from the resident sample of ten did not have a height completed in 2017.

The home’s policy titled Admission/Annual Height, last revised March, 13, 2017, stated “the height of each resident will be taken and recorded annually”.

On January 15, 2018, clinical records for three specific residents were reviewed with the Clinical Coordinator (CC). The CC acknowledged that the three specific residents did not have heights completed for the year 2017 and stated that the residents should have had a height completed in 2017.

On January 16, 2018, the Administrator stated that all residents should have their height measured annually and stated the three specific residents should have had a height measured in 2017.

The licensee has failed to ensure that every resident in the home received a height measurement annually. [s. 8. (1) (b)]

Issued on this 5th day of February, 2018

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

Original report signed by the inspector.