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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 2016	2016_189120_0017	004858-16	Complaint

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST MISSISSAUGA ON L5B 1B5

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 21 and 23, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Environmental Services Supervisor, registered staff, laundry aid and personal support worker.

During the course of the inspection, the inspector toured the laundry room, reviewed the lost and found policy, procedures and forms and reviewed an identified resident's health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee did not ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

The licensee's policy related to lost personal items (ES D-20-30 dated November 11, 2012) was reviewed and it did not include any direction for the management of resident's personal aids such as hearing aids, dentures and glasses. Personal items include personal aids as described under s. 37 of Ontario Regulation 79/10. The policy only included procedures for various staff members to follow with respect to lost clothing items. According to the procedures reviewed, any lost clothing concerns were to be forwarded to the social worker or resident services co-ordinator who would complete the "Missing Clothing Checklist". The staff on the home area and laundry staff were required to conduct a search and the social worker would document the outcome and report the results back to the family. During the inspection, registered staff confirmed that upon admission, residents' personal items were to be documented on an inventory sheet and kept in each resident's health chart. When a new item was acquired, it would be sent to laundry for labeling along with a completed form.

Beginning in mid 2014 and post admission, according to a substitute decision maker (SDM) for an identified resident, a personal aid went missing and verbal complaints were made to various staff members. The aid was not recovered. The resident's written plan of care updated by a charge nurse in May 2014 indicated that the resident used the aid but was non-compliant to using/wearing the aid. In September 2014, another personal aid

was provided to the resident which disappeared in October 2014. A written progress note was made by registered staff in mid October 2014 indicating that staff reported that the resident’s personal aid was missing. A search was conducted and the aid was not found. The progress note indicated that there was "a note left in the communication book" and that "family would be notified". No documentation was completed (Missing clothing checklist or client service response form) and no further progress notes were made with respect to a conclusion. According to the SDM, no personal aid was recovered and no one notified them of the outcome. The social worker who was contacted by the resident's SDM and who was tasked at completing the follow-up was no longer employed at the home and could not be interviewed regarding her involvement.

In early January 2016, a progress note was made by registered staff that the resident's SDM informed her that several specific clothing items were missing. The note revealed that staff looked in the resident's room and the laundry for the resident's items and could not find the items. The note identified that the SDM was notified and that the evening staff would follow up. No missing clothing checklist was completed and the Administrator confirmed that she had not received any forms or was aware of the missing items. The SDM stated that they were not contacted. The SDM reported the same lost items to a registered staff member again in late March 2016 and provided detailed description of the items.

A search of the resident's health care record was completed with the assistance of multiple registered staff and no personal item inventory sheet could be found. A record confirming the existence of certain clothing items and aids upon admission could not be verified. The laundry clothing inventory records were reviewed and no records were kept from 2014 and no records were submitted by staff in 2015 or 2016 for any new items to be labeled for the identified resident. When the SDM brought the resident a personal aid post admission and in September 2014, no inventory records were made to indicate that the resident had an aid and whether it was labeled as required. Several full time registered staff members who were interviewed could not recall if the resident had a specific personal aid in 2014 or 2015. The resident's full time personal support worker could not recall seeing the resident with an aid when interviewed, however she was quoted on a "client service response record" dated January 2015 that she saw the personal aid with the resident in October or November 2014.

The licensee did not develop procedures detailing how personal aids would be managed once acquired and if lost. The procedures involving lost clothing items was not implemented by staff consistently or in each case when a report of lost items was made.

The staff did not consistently complete forms, keep track of the forms, contact the appropriate individuals or have established internal policies if the items could not be located. [s. 89(1)(a)(iv)]

Issued on this 7th day of April, 2016

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

Original report signed by the inspector.