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_0016	010999-15/016939-15	Follow up

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 Follow up inspection.

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

An inspection (2014-189120-0051) was previously conducted on July 30, 2014 at which time non-compliance (Order #001) was issued related to insufficient lighting levels throughout the home. For this follow-up visit, the Order was closed.

An inspection (2015-191107-0001) was previously conducted on January 19-February 5, 2015 at which time non-compliance (Order #005) was issued related to staff to resident abuse. For this follow-up visit, the Order was closed.

See below for additional findings related to this follow-up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, Registered staff and housekeeping staff.

During the course of the inspection, the inspector toured all three floors to measure illumination levels of resident bedrooms, washrooms and corridors, checked sliding glass door security in the 1st floor dining room, determined existence of activation station in the outdoor courtyard, reviewed housekeeping schedules and routines, reviewed abuse and neglect training and education attendance records for all staff and abuse and neglect policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 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. 18.	CO #001	2014_189120_0051	120
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #005	2015_191107_0001	120

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

Illumination levels were taken using a Sekonic Handi Lumi light meter, held parallel to and 30 inches above the floor. On March 21, 2016, two semi private resident bedrooms (#220 and #228) were measured. The drapes were closed and all of the room lights were turned on and allowed to warm up for several minutes. Confirmation was made that every bedroom was equipped with the same number and style of light fixtures. The lights consisted of 2 over bed lights (2 fixtures with 2 bulbs each) an entry ceiling light (LED round with opaque lens) and 2 ceiling lights (LED, round with opaque lens) just above the foot end of resident beds. The level of illumination directly under the smaller LED light at the entry was 150 lux in room #220 and 175 lux in room #228. The illumination level did not change as the meter was carried along path of travel (approximately 4 feet) towards the 1st bed. As the meter approached the foot of the 1st bed, the levels increased to the minimum requirement. The minimum requirement of 215.28 lux was not achieved along path of travel from door entry to 1st bed.

The licensee, in response to Order #001 issued in 2013, increased illumination levels throughout the home by installing additional light fixtures, by replacing ballasts or by replacing fluorescent bulbs. However the selection of the small round LED light in the entry way of each bedroom was found to be insufficient in projecting at least 215.28 lux of light in the entry area. According to the administrator, the company that either provided or installed the fixtures measured the illumination levels and reported that the light fixture met the minimum requirements. Discussion held regarding the need to verify the illumination levels with the contracted company to ensure that the fixtures are adequate. [s. 18.]

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee did not ensure that procedures were implemented for cleaning of the home, including, resident bedrooms, floors, furnishings, contact surfaces and wall surfaces.

The home's housekeeping program is managed by an external contracted service which was developed to include cleaning procedures and routines for housekeeping staff and an auditing component for the Environmental Services Supervisor (ESS) to complete. Policies and procedures reviewed included very detailed tasks for housekeeping staff to follow. The auditing component included a check list of surfaces and areas that were deep cleaned by the housekeeper to ensure that housekeeping staff complied with their routines and procedures. According to the ESS, auditing was random and many were not completed over the last few months. The random audits would require the ESS to ensure that sufficient and effective staffing was allocated to ensure that all areas be maintained in a clean and sanitary state.

1. Random resident rooms were toured on all three floors on March 21, 2016. Heavy amounts of dust was observed on over bed light surfaces in but not limited to bedrooms #236, 234, 233, 228, 225 and 200. Visible matter was seen on the walls next to the toilets in washrooms #200, 201, 203, 204, 210, 211, 214, 217, 219, 222, 223, 225, 227, 230, 234, 236, 237 and 110 on March 21, 2016. The majority of the matter was located in the vicinity of the garbage pail. Some of the washrooms also had sliding bathroom doors with visible matter on them on both sides. Some washrooms had bi-fold washroom doors which were stained in appearance and difficult to clean as they were painted with white paint in a mat finish. When washrooms #222, 223, 236, 237, 225, 214 and 219 were re-visited on March 23, 2016, there was no change to the sanitation levels of the walls. On March 23, 2016, the housekeeper allocated to the 2nd floor was observed while she

cleaned bedrooms #222 and #223. The housekeeper was aware of being monitored and did not have any objections to being monitored. Throughout the process, the housekeeper did not follow the cleaning sequence as described in the policy (from clean to dirty) and did not clean the visible wall matter identified in the washrooms or clean any touch point surfaces such as grab bars, call bell cording, bed rails, door hardware or light switches.

According to policy ES C-10-05 titled "Daily Cleaning Sequence", dated January 21, 2015, the housekeeping staff were required to "spot wipe walls, doors, furniture, bed rails, door knobs, light switches and waste baskets" on a daily basis. The procedure further described the cleaning sequence (from clean to dirty to avoid cross contamination) and to include touch point surfaces such as light switches and bed rails.

2. The common resident washroom located in the 2nd floor dining room was observed to have a build-up of debris on the floor around the baseboard on March 21 and March 23, 2016.

The home's policy ES C-10-05 under the sub title of "Unit Cleaning Procedure" required staff to sweep and damp mop washroom floors on a daily basis.

3. Deep cleaning schedules were reviewed with the ESS and the designated housekeeper for the 2nd floor and according to the schedule, two rooms were to be deep cleaned each day. Two bedrooms (200 and 201) were selected from the list that were reported as being deep cleaned on March 21, 2016. When bedroom #200 was evaluated, it was observed to have soiled washroom walls, debris on the floor behind the bed and along the baseboards behind objects and resident's belongings, very dirty drawers within the night table, the over bed table base was visibly soiled as was the deck of the bed and bed frame.

According to policy ES C-10-05 and the ESS, the deep cleaning process required staff to complete all high dusting, light fixtures, furniture, bed (including frame), walls, doors, floors, vents, window ledges, under beds and furniture (if possible) and would take approximately 45 minutes to complete.

Based on the above observations, the housekeeping program did not appear to be fully implemented with respect to staff adhering to routines and tasks, auditing and assessments to ensure staffing is effective and adequate for the demands of the resident population in the home. Inspections (2014-189120-0052 & 2015-191107-0001)

previously conducted on July 30, 2014 and January/February 2015 resulted in non-compliance related to similar findings related to inadequate sanitation in resident rooms and common spaces. [s. 87(2)(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 procedures are implemented for cleaning of the home, including resident bedrooms, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee did not ensure that the two sets of sliding patio doors to the outdoor courtyard from the main floor dining room were equipped with functioning locks to restrict unsupervised access to the enclosed outdoor area.

The same non-compliance was previously issued on September 3, 2014 on inspection report #2014-189120-0051.

The two sets of glass patio doors were each equipped with basic locks (that slid up and down) within the handle and additional locking hardware with key insert mounted on the meeting stile of the operating door. The added hardware was not in good working order on both sets of doors and both were loosely attached. The sliding locks within the handles were ineffective at keeping residents from gaining access to the courtyard. Both sets of doors were easily slid open during the inspection on March 21, 2016. The non-compliance was reported to the Environmental Services Supervisor on the same date. On March 23, 2016, in the early afternoon, one set of glass patio doors remained unlocked. The hardware, although tightened was not able to keep the door locked. According to the Administrator, a new key lock was installed by end of day March 23, 2016. [s. 9(1)1.1.]

WN #4: 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 :

The licensee did not ensure that the outdoor courtyard was equipped with an activation station that was connected to the resident-staff communication and response system.

The same non-compliance was previously issued on September 3, 2014 on inspection report #2014-189120-0051. The Environmental Services Supervisor was informed on March 21, 2016 and immediate plans were made to have the activation station installed. According to the Administrator, the activation station was installed by end of day March 23, 2016. [s. 17(1)(e)]

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.