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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Aug 29, 2017	2017_561583_0014	014634-17	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

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

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

KELLY HAYES (583), NATASHA JONES (591), SAMANTHA DIPIERO (619)

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): July 12, 13, 14, 17, 18, 19, 20, 21, 24, 25 and 26.

During the course of this inspection, the following additional inspections were conducted:

Complaint Inspections:
Log #002880-17, related to medication administration; log #013155-17, related to an improper transfer; log #012429-17, related to elopement and log #015484-17, related to laundry services and personal support services.

Critical Incident System (CIS) Inspections:
Log # 002681-17, related to improper care; log # 006470-17 and #007132-17, related to falls; log #007433-17, #007791-17, #010204-17, #010208-17, #014182-17 and #013986-17 related to alleged staff to resident abuse and log #014816-17, related to neglect.

On Site Inquires:
Log #005059-17, #005352-17, #006307-17, #007240-17, #008097-17 and log #008185-17.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Clinical Director of Nursing, Business Manager, Programs Manager, Resident Assessment Instrument (RAI) Coordinator, Social Services Worker (SSW), Dietary Manager, Registered Dietitian (RD), Environmental Services Manger (ESM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents and Residents` Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **7 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date in 2017, resident #043 had a fall from an identified location which caused injury.

During a review of the home's investigation notes and through interviews with PSW #128 and #126, it was confirmed that two of resident #043's specified interventions were not in place when the resident was found after their fall. In an interview with the Clinical Director of Nursing #108 in July 2017, it was confirmed that two of the specified fall intervention for resident #043 were not in place as directed in the resident`s plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) inspection, log #006470-17, conducted concurrently during this inspection. (583)

B) On an identified date in 2017, resident #054 shared they had concerns with the care provided by an identified staff member on an identified date in 2017. During the home`s investigation into the incident, interviews were completed with registered staff and PSWs who provided care on the identified date. It was shared that resident #054 had specified responsive behaviours at the time of the incident. Personal Support Worker #131 completed a specific care intervention as they thought it would help the resident's medical condition. At that time the resident had an increase in specified responsive behaviours and the PSW called for more help.

Registered staff #130 came to the resident`s room to assist and it was shared the resident was assisted with another type of specified personal care at which time their responsive behaviour subsided. During this personal care the registered staff left the room and directed the PSW to notify them when they were finished providing care.

The care plan interventions at the time of the incident identified that two staff were required for the two types of personal care that were provided.

In an interview with the Clinical Director of Nursing #108, it was confirmed that on an identified date in 2017, resident #054 was received personal care by one staff twice when the resident required two staff for the personal care provided. It was confirmed that care was not provided by two staff as per the plan of care.

This area of non-compliance was identified during a CIS inspection, log #013986-17, conducted concurrently during this inspection.(583) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident #044's clinical health record indicated they had an unwitnessed fall with injury on an identified date in 2017. The resident had an identified number of recurrent falls over a three month time period.

Observations of resident #044 were made during the course of the inspection and their written plan of care was reviewed.

In interviews in July 2017, PSW #122 and registered staff #112 shared what specific falls prevention intervention strategies were in place for resident #044. These interventions were not included in the resident's written plan of care. The staff further confirmed the resident was not able to use one of the specified interventions due to their medical diagnosis, and another intervention was no longer in place.

A review of the home's policy, titled " Fall Risk assessment", revised April 2010, indicated that interventions based on level of risk were documented in the care plan and electronic interdisciplinary notes.

In interviews in July 2017, the DON and the PT confirmed resident #044's written plan of

care was not revised when their care needs changed.

This area of non-compliance was identified during a critical incident system inspection, log #07132-17, conducted concurrently during this inspection. [s. 6. (10) (b)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On an identified date in 2017, a concern was shared that resident #034 demonstrated the same specified responsive behaviours on three occasions in a 30 day period. Observations of resident #034 throughout the inspection revealed they remained at risk in their current environment due to these specified responsive behaviours.

During the first incident when the responsive behaviours were demonstrated, resident #034 was found by a PSW to be at risk and unattended. The resident was referred to the Behavioral Support Ontario (BSO) nurse and a specified intervention was put in place.

During the second incident when the responsive behaviours were demonstrated, resident #034 was found by visitors of the home in the same unsafe environment as the previous incident, unattended.

During the third incident when the responsive behaviours were demonstrated, resident #034 was found by staff in the same unsafe environment as the previous two incidents, unattended.

A review of resident #034's written plan of care, identified the resident was at high risk for these responsive behaviours, but did not include interventions for monitoring and/or managing the behaviours. In interviews in July 2017, PSW #121 and registered staff #115 it was shared that one intervention was put in place after the first incident but this intervention was not effective in preventing the second two incidents. The staff identified possible know triggers that put the resident in an unsafe environment during the following two incidents.

In an interview on July 25, 2017, the DON and the ESM it was identified that there were certain circumstance when the initial intervention that was put in place for resident #034 would not be effective in keeping the resident in a safe and secure environment. It was confirmed that the home did not ensure resident #034's environment was safe and secure.

This area of non-compliance was identified during a complaint inspection, log #012429-17, conducted concurrently during this inspection. [s. 5.]

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 a safe and secure environment for residents, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that the resident was not neglected by staff.

On an identified date in 2017, the resident #041 was observed to demonstrate a medical condition at a specified time along with identified responsive behaviours. At that time RN #112 was made aware that the resident was on a medication that could exacerbate the resident's medical condition.

A review of the progress notes indicated that the Nurse Practitioner was contacted by RN #112 and informed of the resident's condition; however, it was not reported to the Nurse Practitioner that the resident's condition was on-going and that the resident was on a medication that could exacerbate the condition.

In a recorded interview with RN #112, they confirmed that they reviewed resident #041's MAR and did not recognize that the resident was on a medication that had potential to exacerbate the resident's medical condition. Approximately six hours later, the resident's family/person of importance requested a second opinion, from the oncoming registered staff as the resident's medical condition had not improved. A review of the progress notes indicated that RPN #113 assessed the resident and transferred the resident to hospital for further treatment and assessment.

A review of resident #041's medication administration record (MAR) indicated that the resident was taking a specified medication that had potential to exacerbate the resident's condition, and had been on this medication for over two years. A review of the resident's written plan of care, also advised staff to monitor for the signs of the medical condition the resident was experiencing when this medication was being administered.

A review of the home's policy titled, "Abuse and Neglect Policy", policy # RCS P-10, last revised July 2, 2015, stated, "the home has zero tolerance for the abuse and neglect of resident's", and clarifies further stating, "neglect means the failure to provide a resident with treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Interview with the DON confirmed that RN #112 was neglectful in their care of resident #041 when they failed to use critical judgment and nursing best practice skills while assessing the resident, failed to recognize the resident's use of the specified medication, and caused a delay in the resident accessing treatment.

This area of non-compliance was identified during a complaint inspection, log #002880-17, conducted concurrently during this inspection. [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 residents are not neglected by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturers' instructions.

During the initial tour of the home on July 12, 2017, at 1030 hours in an identified Spa Tub/Shower room Inspector #619 observed the Alenti Hygiene Chair without a seat belt attached. On further observation the inspector determined that instructions for the Alenti lift were not posted in the spa tub area and were not available at the nursing station.

Interview with RPN #114 indicated that the Alenti lift was used for tub baths for a small number of capable residents, and also used to measure resident weights. Registered Practical Nurse #114 indicated that there was no seat belt in use for this lift and that staff employed the lift without securing residents. Interview with RN #103 confirmed that the lift chair was taken out of service until a seat belt could be obtained to enable correct usage of the Alenti lift chair.

A review of the manufacturer's instructions titled,"ArjoHuntleigh Getinge Group: Alenti Instructions for Use", manual # 04.CD.05_5GB, updated September 2010, directed that, the use the safety belt was required at all times, the safety belt helps the resident stay positioned properly on the seat and to always attach the safety belt before the resident is seated in the Alenti chair.

Interview with the Administrator and the DOC confirmed that the Alenti lift chair was used by staff on the second floor without the use of the required seat belt. The Administrator confirmed that the staff did not use this equipment in accordance with the manufacturers' instructions. [s. 23.]

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 staff use equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturers` instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices and techniques when assisting residents.

A review of the resident #052's written plan of care, identified that the resident required extensive staff assistance for all activities of daily living and required two staff for all lifts and transfers using a specified type of mechanical device.

On an identified date in 2017, staff #132 witnessed PSW #117 attempting to complete an unsafe transfer with resident #052. Interview with staff #132 indicated that they witnessed PSW #117 attempting to transfer resident #052 via a specified type of mechanical device and that the resident was in distress related to positioning.

In a recorded interview, PSW #118 indicated that they could not find assistance to transfer the resident after providing care. In an interview with PSW #118 it was confirmed that they were aware the the resident required two staff for care and transfers. It was confirmed that both the residents care and transfer using a mechanical device were completed by one staff. On further investigation, it was also determined that prior to this incident on the same day the resident was transferred by, PSW #118 and PSW #119 using the incorrect mechanical device.

A review of the home's policy titled, "Resident Safety – Transfers", policy # RCS E-20, last revised March 31, 2017, stated, "Resident's requiring the use of a mechanical lift and/or ceiling lit will be assisted by two staff to promote both resident and staff safety."

Interview with DON confirmed that on two occasions on an identified date in 2017, PSW #118 and PSW #119 transferred resident #052 in an unsafe manner.

This area of non-compliance was identified during a CIS inspection, log #013155-17, conducted concurrently during this inspection. [s. 36.]

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 staff use transferring and positioning devices and techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours where possible, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #034 demonstrated the same specified responsive behaviour on three separate occasions over an identified 30 day time period. Observations of resident #034 throughout the inspection revealed that the resident remained at risk to demonstrate the same responsive behaviour in their current environment.

During the first incident when the responsive behaviours were demonstrated, resident #034 was found by a PSW to be in an unsafe environment unattended. The resident

was referred to the Behavioral Support Ontario (BSO) nurse and a specified intervention was put in place.

During the second incident when the responsive behaviours were demonstrated, resident #034 was found by visitors of the home in the same unsafe environment as the previous incident, unattended.

During the third incident when the responsive behaviours were demonstrated, resident #034 was found by staff in the same unsafe environment as the previous two incidents, unattended.

A review of resident #034's written plan of care, identified the resident as high risk for this specified responsive behavior, but did not include behaviour related strategies for monitoring and/or assisting the resident when they were at risk of demonstrating the specified responsive behaviour.

A review of resident #034's written plan of care, identified the resident was at high risk for these responsive behaviours, but did not include interventions for monitoring and/or managing the behaviours. In interviews in July 2017, PSW #121 and registered staff #115 it was shared that one intervention was put in place after the first incident but this intervention was not effective in preventing the second two incidents. The staff identified possible know triggers that put the resident in an unsafe environment during the following two incidents. It was confirmed action was not taken with reassessment of the resident after the second and third incident and new interventions were not implemented.

In an interview in July 2017, the DON confirmed resident #034 demonstrated the specified responsive behaviour on three occasions as a result of the same trigger each time. The DON confirmed resident #034 was assessed as being a high risk for this specified responsive behaviour; however, the home did not develop or implement new strategies to respond to the resident's recurrent specified responsive behaviours. It was confirmed that action was not taken to respond to the needs of resident #034.

This area of non-compliance was identified during a complaint inspection, log #012429-17, conducted concurrently during this inspection. (591) [s. 53. (4)]

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours where possible, and actions are taken to respond to the need of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: 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 :

1. As part of the organized program of laundry services under clause 15(1)(b) of the Act, the licensee failed to ensure that, procedures were developed and implemented that ensured ii) residents` clothing were labelled within 48 hours of admission and of acquiring, in the case of new clothing, and that there was a process to report and locate residents` lost clothing.

A) A complaint was made to the home after resident #053 identified their clothes were not being returned from laundry. On an identified date in 2017, the resident's clothing was stained after a meal and there were no clothing items available in the resident's

closet. During this time after a search in the laundry department some of the clothing was located and then labelled.

Resident #053`s "Inventory of Personal Valuables" identified on admission the resident a specified number of clothing articles.

Resident #053`s ``Inventory of Personal Valuables`` forms were reviewed with the Environmental Services Manager in July 2017 and it was verified that the documentation on the resident's "Inventory of Personal Valuables" forms were not completed and did not identify the date the clothes were received or whether the clothing was labelled.

B) A complaint related to resident #010's clothes not coming back to the resident's room after they go to laundry was identified. In an interview with registered staff #115 in July 2017, it was shared that staff could not find any pants for the resident that morning and had to go to the laundry department to find clothing for the resident.

According to the home's ``Clothing Inventory Procedures`` the clothing inventory form was kept in a binder in the Environmental Manger`s Office. In an interview with the Environmental Services Manger in July 2017, it was confirmed that they did not have a clothing inventory form for resident #010 in their binder. It was confirmed that the inventory form found on the resident's chart had clothing items brought in on admission but the date received was not documented and it was documented that none of the clothing was labeled. There was no documentation to show that the clothing had received labeling.

In an interview with the Environmental Services Manger it was shared that the home had a day for family and residents to look over unlabelled clothing as there was a large number of items that were currently unlabelled in the laundry department. It was confirmed that the laundry services procedure outlined in "Clothing Inventory Procedure", revised on July 15, 2013, were not implemented and the home was in the process of redeveloping them.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #015484-17, and CIS inspection, log #014816-17, conducted concurrently during this RQI. [s. 89. (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 procedures are developed and implemented that ensure ii) residents` clothing is labelled within 48 hours of admission and of acquiring, in the case of new clothing, and that there is a process to report and locate residents` lost clothing, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

In an interview on an identified date in 2017, resident #048 stated on a specified day in 2017, a PSW staff on the evening shift refused to assist the resident to bed when they requested. The resident stated that they had requested several times over a two hour time period for assistance from the staff member to go to bed, and that most of the other residents had already been assisted, including their roommate; however, the PSW ignored them and did not assist them to bed till approximately two hours later. Resident #048 reported the incident to the charge nurse.

A review of resident #048's plan of care indicated their usual bed time preference was in the middle of the two hour time period they were requesting to be put to bed. A review of the home's internal investigation notes concluded the staff member did not respect the resident's right to be assisted as requested and that their conduct was not acceptable.

In an interview in July 2017, it was confirmed that resident #048's desired bedtime was not supported to promote comfort, rest and sleep.

This area of non-compliance was identified during a CIS inspection, log #010208-17, conducted concurrently during this inspection. [s. 41.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that each resident who is unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A review of the resident #042's written plan of care, identified that the resident required the assistance of one staff to complete care after episodes of incontinence. On an identified date in 2017, RN #112 was made aware of a concern that resident #042 had not received the assistance they required with continence care. A review of the call bell records for the specified date of concern indicated that the resident rang for assistance at an identified time. Interview with PSW #106 indicated that they reported the care need to PSW #105 and failed to inform RPN #107. PSW #105 provided continence care to resident #042 approximately one hour after they had initially requested assistance.

A review of the home's policy titled, "Personal Hygiene and Grooming", policy #RCS D-05, last revised January 31, 2017, stated, "Incontinent residents will receive care after each episode of incontinence".

Interview with the DON confirmed that staff should provide continence care in a timely fashion and that the home's staff failed to do so as a result of communication errors.

This area of non-compliance was identified during a CIS inspection, log #002681-17, conducted concurrently during this inspection. [s. 51. (2) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) 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; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program had a system to monitor and evaluate the food intake of residents with identified risks related to nutrition and hydration.

Resident #028 was assessed to be at moderate nutrition risk and last assessed by the Food Service Manager on an identified date in May 2017. The look back reports were reviewed and showed that the resident had a decrease in their intake in July, 2017.

After reviewing the look back reports and reading the home's "Food and Nutritional Services Manual" policies it was identified that the home did not have a system in place to monitor and evaluate food intake. The home monitored and documented food and fluid intake in Point of Care and the nursing staff evaluated resident fluid intakes and referred to the RD based on set parameters.

In an interview with the RD on July 26, 2017, it was confirmed that the nursing staff were not reviewing food intake when reviewing the nutrition look back report, parameters were not in place to identify when a referral to the RD was required and the current policies did not have a procedure for monitoring or evaluating food intake for residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

WN #11: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for the cleaning and disinfection of devices in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On an identified date in July, 2017, resident #028 was observed sitting in their wheelchair by Inspector #591. The wheelchair was noted to be unclean.

The "Environmental Services, Equipment Cleaning/Repairs, Index I.D. RCS M-30" policy, revised September 20, 2013, was reviewed. The procedure directed staff to wipe off all spills immediately who observe it and to clean all wheelchairs weekly as per the cleaning schedule. The night cleaning schedule for resident #028's weekly deep clean was signed of as being completed.

On an identified date in July 2017, Inspector #583 completed a second observation for resident #028. The wheelchair was again noted to be unclear, with the same noted debris as identified in the first observations 2 days earlier.

In an interview with registered staff #115 in July 2017, it was confirmed that resident #028's device was dirty and not cleaned as required. [s. 87. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On July 12, 2017, at 1005 hours during the initial tour of the home, the Inspector discovered an unmonitored and unlocked medication cart on the third floor home area. The Inspector was able to open all the drawers in the cart and observe medical supplies, medicine, and personal health information of residents living on the third floor. Interview with RPN #104 confirmed that the medication cart was unlocked and that the medications were not secure. A review of the home's policy titled, "Medication System – Medication Storage", last reviewed January 2017, which identified, the medication cart was to be locked at all times when not in use and that medications stored in the medication cart should be locked and secured at all times.

Interview with the Administrator confirmed that all registered staff who administer medication are responsible for the safety of the medication cart by ensuring it is secured and locked when not in use and that this was not completed. [s. 129. (1) (a)]

Issued on this 8th day of September, 2017

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) :	KELLY HAYES (583), NATASHA JONES (591), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2017_561583_0014
Log No. / No de registre :	014634-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 29, 2017
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NICOLE FISHER

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure the following:

1) That activities of daily living are provided by two staff members when directed in the resident`s plan of care for resident #054.
2) That interventions set out in the falls plan of care are provided for residents at high risk of falls as specified in their plans.
3) That the home has an auditing process in place to ensure care is being provided as directed in the plan of care for residents in the home.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is isolated (1), the severity of the non-compliance has actual harm or risk (3) and the history of one or more related non-compliance in the past three years, under Ontario Regulation 79/10, r. 110. (1) 1 is ongoing (4) with a VPC in 2015 and 2016.

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date in 2017, resident #043 had a fall from an identified location which caused injury.

During a review of the home's investigation notes and through interviews with PSW #128 and #126, it was confirmed that two of resident #043's specified interventions were not in place when the resident was found after their fall. In an

interview with the Clinical Director of Nursing #108 in July 2017, it was confirmed that two of the specified fall interventions for resident #043 were not in place as directed in the resident`s plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) inspection, log #006470-17, conducted concurrently during this inspection. (583)

B) On an identified date in 2017, resident #054 shared they had concerns with the care provided by an identified staff member on an identified date in 2017. During the home`s investigation into the incident, interviews were completed with registered staff and PSWs who provided care on the identified date. It was shared that resident #054 had specified responsive behaviours at the time of the incident. Personal Support Worker #131 completed a specific care intervention as they thought it would help the resident's medical condition. At that time the resident had an increase in specified responsive behaviours and the PSW called for more help.

Registered staff #130 came to the resident`s room to assist and it was shared the resident was assisted with another type of specified personal care at which time their responsive behaviour subsided. During this personal care the registered staff left the room and directed the PSW to notify them when they were finished providing care.

The care plan interventions at the time of the incident identified that two staff were required for the two types of personal care that were provided.

In an interview with the Clinical Director of Nursing #108, it was confirmed that on an identified date in 2017, resident #054 was received personal care by one staff twice when the resident required two staff for the personal care provided. It was confirmed that care was not provided by two staff as per the plan of care.

This area of non-compliance was identified during a CIS inspection, log #013986 -17, conducted concurrently during this inspection. (583)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

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 29th day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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