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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
May 30, 2018	2018_543561_0005	007101-18	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

DARIA TRZOS (561), FARAH_ KHAN (695), JANET GROUX (606), JESSICA PALADINO (586)

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): April 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 2018.

The following Follow Up (FU) Inspection was completed concurrently with this Resident Quality Inspection (RQI):
022272-17 - related to care not provided as specified in the plan.

The following Complaints and Critical Incidents were inspected concurrently with

this RQI:

Complaint:
017574-17 - related to multiple care areas.

Critical Incidents:
026583-17 - related to incompetent treatment of a wound
025615-17 - related to unsafe transfer
022895-17 - related to an alleged abuse causing an injury.

The following Inquiries were completed concurrently during this RQI:
015582-17 - related to alleged staff to resident abuse
016384-17 - related to alleged staff to resident abuse
022896-17 - related to alleged staff to resident abuse
024682-17 - related to alleged visitor to resident abuse
018501-17 - related to an unexpected death
029453-17 - related to concerns of shortage of staff
004655-18 - related to alleged staff to resident abuse
007893-18 - pest control and dirty radiators.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Clinical Directors of Nursing (CDONs), Programs Manager, Social Service Worker, Environmental Services Manage (ESM), Registered Dietitian (RD), Physiotherapist, Restore Program Coordinator, Quality Improvement Coordinator, Resident Assessment Instrument (RAI) Coordinator, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, President of the Resident Council, President of the Family Council, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
11 WN(s)
4 VPC(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_561583_0014	561

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. 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 techniques when assisting residents.

A CIS report 2124-000031-17 was submitted to the Director on an identified date in 2017 related to alleged abuse of resident #019 by staff causing an injury to the resident. Resident #019’s documented plan of care indicated that the resident required two-person extensive assistance for transfers.

On an identified date in 2017, the resident sustained an injury requiring transfer to hospital for treatment.

In an interview with the resident following the incident, they explained to the SSW, RN #108 and the Administrator that they were transferred by one staff member, PSW #121, indicating that they themselves had requested a second person but no other staff came in. Resident sustained an injury during the transfer.

PSW #125 who was also responsible for resident #019’s care confirmed that they did not assist with the transfer.

Through the home’s internal investigation, it was determined that the resident was independently transferred sustaining an injury. In an interview with the Administrator and DOC during inspection, it was confirmed that the resident was transferred with only one staff member present rather than two staff as per their plan of care. They acknowledged that the resident was unsafely transferred resulting in significant injury to the resident.

This area of non-compliance was identified during CIS Inspection log #022895-17 conducted concurrently with the RQI. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A CIS report 2124-000035-17 was submitted to the Director on an identified date in 2017 related to an unsafe transfer. The CIS indicated that PSW #106 used the wrong part of equipment during transfer of resident #013. The investigation notes were reviewed and stated that PSW #106 and PSW #107 were transferring the resident and used the wrong part of the equipment. PSW #106 told the home during the interview that they used this equipment because this was the only one available at the time.

The plan of care effective at the time of the incident was reviewed and did not specify which type of equipment was to be used for the resident.
PSW #106 was interviewed by Inspector #561 and stated what type of equipment they used.

The DON was interviewed and indicated that each resident is assessed for the type of equipment to be used and the plan of care should clearly state that. The DON confirmed that the written plan of care at the time of the incident and the kardex did not provide clear direction to staff related to the type of equipment used for transfers.

The licensee failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to the resident in relation to transfers.

This area of non-compliance was identified during CIS Inspection log #025615-17 conducted concurrently with the RQI. [s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including skin and wound care, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

The home's program titled "Skin Care and Wound Management Program," revised April 2010, indicated that referrals were to be made to other disciplines if clinically indicated when there was a significant change in health status.

The CIS report 2124-000037-17 was submitted to the Director on an identified date in 2017 in relation to an alleged incompetent treatment of resident #015.
The progress note from Registered Nurse (RN) #126 on an identified date in 2017, indicated that residents altered skin integrity has deteriorated with signs of potential infection.

During an interview with RN #126, they confirmed that they documented signs of deterioration in progress notes. The Wound Care Nurse was away at the time and the RN stated that they were not aware of the state of the skin integrity since they had not worked on the shift that same week. They were not able to compare the status of the skin to any previous assessments. They did the dressing change and did not make any referrals.

Clinical record reviewed indicated there were no referrals made to the Nurse Practitioner (NP) when there was a significant deterioration on an identified date in 2017. Clinical record review indicated that few days later, resident #015 was diagnosed with a medical condition and required treatment.

The DON was interviewed and stated that the RN should have called the NP when resident #015’s health had deteriorated. DON confirmed that based on the progress note, it was clinically indicated to contact the NP for an assessment.

The licensee failed to ensure that their Skin and Wound Management Program was complied with. (695)

This area of non-compliance was identified during CIS Inspection log #026583-17 conducted concurrently with the RQI.

B) In accordance with O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs are used in the home and that (3) The written policies and protocols must be (b) developed, implemented, evaluated, and updated in accordance with evidenced-based practices, and, if there are none, in accordance with prevailing practices.

During the RQI, a medication inspection protocol was initiated as a mandatory inspection to inspect the home’s medication management system.

Review of the home's policy titled, “Transcribing Physician's Orders or RN Extended Class (EC)'s Orders”, Index I-D. RCS F-65, revised July 15, 2014, indicated that the pharmacy will enter the orders in the Point Click Care (PCC) Electronic Medication Administration Record (E-MAR). The registered staff will verify these orders for accuracy.

Review of a medication incident report dated in 2018, indicated the NP wrote an order to discontinue a medication for resident #002. The report indicated the pharmacy discontinued the previous order but did not create a new order of the medication for a specific time of the day.

The plan of care was reviewed including progress notes and E-MARs for resident #002 and indicated that the medication order was changed by NP; however, was not clarified and part of the order was omitted in E-MAR for an identified period of time and specific time.

Review of the home's investigation indicated corrective actions of the medication incident was initiated and clarification with the NP and the pharmacy was completed to confirm the order.

Interview with the DON indicated that it is the responsibility of the registered staff to ensure that all orders are checked to ensure for accuracy and should have followed the above mentioned policy.

The licensee failed to ensure that the Transcribing Physician's Orders or RN Extended Class (EC)'s Orders policy was complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident’s condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A CIS report 2124-000037-17 was submitted to the Director on an identified date in 2017 in relation to an alleged incompetent treatment of resident #015.

The progress note from Registered Nurse (RN) #126 on an identified date in 2017, indicated that resident had a deterioration of the altered skin integrity.
Clinical records were reviewed and an assessment of the status of resident #015 could

not be found.

During an interview with RN #126, LTCH Inspector #695 confirmed that the RN noted a deterioration. On an identified date in 2017 resident was diagnosed with a health condition and required treatment.

During an interview with the DON, they stated that it was expected that RN #126 completed a clinically appropriate skin assessment when there was a change in condition of resident's skin integrity.

The licensee failed to ensure that resident #015 received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when there was a change in the condition.

This area of non-compliance was identified during CIS Inspection, log # 026583-17, conducted concurrently with the RQI. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity was assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A CIS report 2124-000037-17 was submitted to the Director on an identified date in 2017 in relation to an alleged incompetent treatment of resident #015.

During an interview with Registered Nurse (RN) #115, the Wound Care Nurse, LTCH Inspector #695 was informed that resident #015's skin was intact on an identified date in 2017, when they last provided treatment.

Resident #015 was diagnosed with a health condition as per the Nurse Practitioners progress notes.

In an interview with the RD, they stated that RD referrals were expected to be made when there are new or worsening areas of altered skin integrity. The RD also confirmed that no referrals were received for resident #015 after being diagnosed with the health condition and after noting an alteration of the skin integrity.

The policy "Skin Care and Wound Management Program," with a revised date of April

2010, stated to refer to the Registered Dietitian (RD) when there is skin breakdown present (Stage 2 to unstageable) or any new skin breakdown.

During an interview with DON it was confirmed that it was an expectation for registered staff to refer to an RD when there was a new or worsening area of altered skin integrity.

The licensee failed to ensure that when resident #015 developed an alteration of the skin integrity and was prescribed a treatment for the health condition that a referral was made to the RD to reassess their condition and make appropriate changes to the plan of care.

This area of non-compliance was identified during CIS Inspection, log # 026583-17, conducted concurrently with the RQI. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

A CIS report 2124-000037-17 was submitted to the Director on an identified date in 2017 in relation to an alleged incompetent treatment of resident #015.

The home's investigation notes from CI 2124-000037-17 included a copy of the Electronic Treatment Administration Record (E-TAR). The copy had a note in handwriting stating no weekly wound assessments found for the days that they were expected to be done.

RN #123 was interviewed by LTCH Inspector #695 and stated that wound care treatment was completed on an identified date in 2017; however, the weekly skin assessments were not completed on two prior occasions and should have been done.

RN #115 was interviewed who is the Wound Care Nurse in the home, and stated that it was expected that registered nurses complete weekly wound assessments while they were away in 2017.

The home’s policy “Skin Care and Wound Management Program,” with a revised date of April 2010, directs registered staff to complete skin and wound assessments weekly for residents with altered skin integrity.

DON was interviewed and stated that the weekly wound care assessments were not completed, as expected from registered staff.

The licensee failed to ensure that resident #015’s skin alteration was reassessed at least weekly by a member of the registered staff when exhibiting altered skin integrity in 2017.

This area of non-compliance was identified during CIS Inspection, log # 026583-17, conducted concurrently with the RQI. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident’s condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

During stage one of the RQI, it indicated that resident #014 had a new alteration of the skin integrity triggered from the Minimum Data Set (MDS) assessment in 2018.

Record review of resident #014’s progress notes, indicated resident was identified with two areas of the altered skin integrity. Further record review of the progress notes indicated the wound was healed on an identified date in 2018.

Review of resident #014’s written plan of care, identified that the resident was at risk for impaired skin integrity related to multiple health conditions and one of the interventions directed staff to turn, reposition the resident at least every two hours, and more often as needed or upon request by the resident.

The LTCH Inspector #606 observed on an identified date in 2018 that resident #014 was not turned and/or repositioned by anyone for approximately four hours on the day of observations.

Interview with resident #014 indicated that they get up for breakfast in the morning and stayed up in their wheelchair until after lunch and returned to bed with staff assistance after they had lunch. Resident #014 indicated that they found it tiring and difficult at times to sit in their wheelchair all morning and staff had not approach them that morning to be assisted to turn and reposition in their chair.

Interview with PSW #105 indicated that resident #014 was at risk for skin integrity impairment and indicated that the resident’s plan of care directed staff to turn and reposition the resident at least every two hours to prevent the risk of skin breakdown.

The PSW confirmed that they got busy with other residents that shift and therefore was not able to turn and reposition resident #014 as indicated on their care plan.

Interview with the Charge Nurse, RN #136 indicated the resident #014 was at risk for impaired skin integrity and required to be turned and repositioned as scheduled in their care plan.

The licensee failed to ensure that resident #014 who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. [s. 50. (2) (d)]

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 a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; to ensure that a resident exhibiting altered skin integrity is assessed by a registered dietitian who is a member of the staff of the home; to ensure that a resident exhibiting altered skin integrity, is reassessed at least weekly by a member of the registered nursing staff; to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the RQI, a medication inspection protocol was initiated as a mandatory inspection to inspect the home's medication management system.

Record review of a medication incident report on an identified date in 2018, reported that resident #028 was administered the wrong medications.

Review of the home's investigation indicated actions were taken to provide follow up with resident #028. The resident was monitored closely and vital signs were obtained every one hour for six hours then every two hours for six hours. The physician was notified and consulted. The investigation indicated that the severity and outcome of the medication incident resulted in a level two indicating that there was no harm to resident #028.

Record review indicated that RPN #037 gave the medications to resident #028 assuming that they were resident #030, resident #028 was not wearing an identification bracelet.

Review of the medication incident indicated that education and an audit of residents was completed to ensure any resident who were not wearing an identification bracelet were provided with one.

Interview with the DON indicated that resident #028 received the wrong medications and stated RPN #136 was a new staff and had received training and education as a follow up to the above mentioned incident.

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #6: 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 :

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

During the initial tour of the home on April 11, 2018, the ‘Dirty Utility Room Laundry Chute’ door was observed to have a door handle with no lock, and a large hole in the door where a lock should have been. The door was unable to be locked and when opened, revealed an unlocked laundry chute that could be opened by the LTCH Inspector. This was brought to the DON’s attention who acknowledged that the door should have been equipped with a lock and locked when not in use. The home took immediate action to mitigate the risk. [s. 5.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During this RQI, LTCH Inspector noted several areas in the home that were not kept clean and sanitary throughout the inspection. The areas included the following:
- baseboards in the dining room on the third floor were noted to be dirty,
- the outside of the radiators on the third floor of the dining room had stains on the side and stains from coffee cups on top of the radiators,
- window cells on the third floor dining room were dusty,
- debris found under the servery on the third floor dining room,
- debris under the servery area on the second floor dining room,
- stool legs on the second and third floors dining rooms were noted to have stains and dried food particles,
- baseboards in the hallway of the third floor were note to be dirty,
- crumbs were found on the second floor dining room,
- the floors were dirty and had dust present, especially in the corners of the main kitchen,
- debris found under the dishwasher areas of the kitchen,
- doors to the kitchen were found to be sticky and dirty,
- the outside of the freezers were observed dirty and sticky.

The policies and procedures related to housekeeping were reviewed and did include schedules for regular and deep cleaning; however, the areas identified still continued to remain dirty.

The Administrator was interviewed and accompanied LTCH Inspectors #561 and #586 to the areas identified above and confirmed that those areas were not kept clean and

sanitary.

The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

The plan of care for resident #013 indicated that resident was assessed to be at high risk for falls and required to have a device in place as an intervention to prevent falls. On April 18, 2018, resident #013 was observed to have the device applied; however, the LTCH Inspector was unsure if the device was in working condition.
Interviewed the PSW #106 who provided direct care to the resident and confirmed that resident required to have the device applied. Requested the PSW to demonstrate how the device worked. The PSW checked the device and it was not working. The PSW indicated that it required a battery change and that they reported this to the nurse in charge few days ago. PSW removed it and the batteries were changed by registered staff.

The Clinical Director of Nursing (CDON) was interviewed and stated that the PSWs were responsible to check if these devices are functioning before use and if they are not, then they were required to report this to the nurse in charge. The nurse in charge had access to falls equipment and batteries.

The DON was interviewed on April 23, 2018 and stated that PSWs were expected to check if the devices were functioning on every shift. If there was an issue they were to report it to the charge nurse.

The licensee failed to ensure that the equipment was kept in good repair and were functioning. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the written record of the annual Falls Prevention program included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the dates of when those changes were implemented.

The 2017 Annual Program Evaluation for the Falls Prevention program was reviewed by LTCH Inspector #561. The evaluation did not include the date that the changes were implemented based on the annual program evaluation.
The DON was interviewed and confirmed that the annual program evaluation report for the Falls Prevention program included the summary of the changes; however, there were no dates that those changes were implemented. [s. 30. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident, if payment was required.

Resident #010 told LTCH Inspectors #695 and #561 that they had lost their dentures prior to moving to the LTC home and had been without them since that time. A week later, the resident told LTCH Inspector #586 that they had not been offered dental services since their admission to the home.

In interviews with the Admissions Coordinator and the Social Service Worker, both indicated that the external dental provider was responsible for calling the residents and families twice per year using an updated list supplied from the home bi-annually in March and August of each year. This consisted of a print out of each resident's contact list under the 'Profile' tab in Point Click Care (PCC).

The Program Manager indicated that resident #010's SDM was offered dental services in 2017 and declined. This was confirmed through review of the dental service's list provided by the home.

In an interview with the Social Services Worker, they confirmed that the resident's SDM was contacted to offer dental services to resident #010 in 2017, which was greater than one calendar year. They also indicated that the resident was capable of making their own care decisions and acknowledged that resident #010 should have been offered the dental care services directly to them, rather than to their SDM. The resident was not offered an annual dental assessment. [s. 34. (1) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the Pharmacy Service Provider and a Registered Dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the RQI, a medication inspection protocol was initiated as a mandatory inspection to inspect the home’s medication management system.

Record review of the home’s annual evaluation of the home’s medication management system entitled, “Quality Management-Long Term Care (LTC) Program/Committee Evaluation Tool-Medication Management Program and Pharmacy Committee”, dated March 6, 2017, indicated that evaluation did not include the home’s Medical Director, the Administrator, the Pharmacy Service Provider and the Registered Dietitian.

Interviews with the DON, the CDON and the Quality Improvement Coordinator confirmed the home’s medication management system annual evaluation did not include the

home's Medical Director, the Administrator, the Pharmacy Service Provider, and the Registered Dietitian.

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the Pharmacy Service Provider and a Registered Dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 116. (1)]

2. The licensee failed to ensure that the annual evaluation of the medication management system:
(a) included a review of the quarterly evaluations in the previous year as referred to in section 115, (b) used an assessment instrument designed specifically for this purpose, and (c) identified changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During the RQI, a medication inspection protocol was initiated as a mandatory inspection to inspect the home's medication management system.

Record review of the home's annual evaluation of the home's medication management system entitled, "Quality Management-Long Term Care (LTC) Program/Committee Evaluation Tool-Medication Management Program and Pharmacy Committee", dated March 6, 2017, indicated that evaluation did not include a review of the home's quarterly medication incidents evaluations for the previous year.

Interviews with the DON, the CDON and the Quality Improvement Coordinator indicated that medication incidents were not reviewed during the 2017 annual medication management system because the home focused on other identified goals.

The licensee failed to ensure that the annual evaluation of the medication management system: (a) included a review of the quarterly evaluations in the previous year as referred to in section 115, (b) used an assessment instrument designed specifically for this purpose, and (c) identified changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 116. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home were kept at the home

A) During stage one of the RQI, census review and staff interview indicated resident #013 had an alteration of skin integrity.

Record review of resident #013's progress notes on an identified date in 2017, indicated the resident had an alteration of skin integrity.

Review of resident #013's physician orders and E-TARs, indicated a treatment order was to be administered every Monday, Wednesday, and an order that every Friday an assessment in Pixalere and as needed (PRN).

Interviews with RPNs #122 and #135 indicated that the home would have completed a weekly skin assessment for residents with any skin integrity impairment prior to March 2018 in Pixalere, a software for the skin and wound program. They indicated that the home had discontinued the use of Pixalere as of March 2018 and were now using the PCC to assess and document all weekly skin and wound assessments. They indicated that they no longer have access to Pixalere and were unable to provide the LTCH Inspector assistance in obtaining any weekly skin assessments completed.

Interview with the home's Wound Care Nurse, RPN #115, indicated that weekly skin assessments were done for resident #013 in Pixalere but indicated that the home no longer used Pixalere and was no longer able to retrieve any information. They indicated that head office had been contacted for assistance in obtaining the weekly skin assessments for resident #013 but head office was not able to retrieve the identified skin assessment for resident #013.

The weekly skin assessments completed in Pixalere for resident #013 was not available for review.

The licensee failed to ensure that the records of resident #013's weekly skin assessments, were kept at the home.

B) During stage one of the RQI, it indicated that resident #014 had a new altered skin integrity triggered from the MDS assessment.

Record review of resident #014's progress notes, indicated resident was identified with several altered skin integrity areas.

Review of resident #014's physician orders and the E-TARs, indicated resident #014 was to receive a weekly assessment of the areas until healed.

Interviews with RPNs #122 and #135 indicated that the home would have completed a weekly skin assessment for resident #014 in Pixalere. They indicated that the home had discontinued the use of Pixalere as of March 2018 and were now using the PCC to assess and document all weekly skin and wound assessments. They indicated that they no longer had access to Pixalere and were unable to provide the LTCH Inspector assistance in obtaining any weekly skin assessments completed for resident #014's.

Interview with the home's Wound Care Nurse indicated that weekly skin assessments were done for resident #014 in Pixalere but indicated that the home no longer used Pixalere and was no longer able to retrieve any information.

The weekly skin assessments for resident #014 were not available for review.

The licensee failed to ensure that the records of resident #014's weekly skin assessments were kept at the home. [s. 232.]

Issued on this 8th day of June, 2018

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

Original report signed by the inspector.

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) :	DARIA TRZOS (561), FARAH_ KHAN (695), JANET GROUX (606), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2018_543561_0005
Log No. / No de registre :	007101-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 30, 2018
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

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To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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.

Order / Ordre :

The licensee must be compliant with O.Reg 79/10 s. 36.

Specifically, the licensee must:
1. Ensure that all residents that require two person extensive assistance for transfers that staff use safe techniques including using two person assistance when assisting residents.

Grounds / Motifs :

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

Resident #019's documented plan of care indicated that the resident required two-person extensive assistance for transfers.

On an identified date in 2017, the resident sustained an injury requiring transfer to hospital for treatment.

In an interview with the resident following the incident, they explained to the SSW, RN #108 and the Administrator that they were transferred by one staff member, PSW #121, indicating that they themselves had requested a second person but no other staff came in. Resident sustained an injury during the transfer.

PSW #125 who was also responsible for resident #019's care confirmed that they did not assist with the transfer.

Through the home's internal investigation, it was determined that the resident was independently transferred sustaining an injury. In an interview with the Administrator and DOC during inspection, it was confirmed that the resident was transferred with only one staff member present rather than two staff as per their plan of care. They acknowledged that the resident was unsafely transferred resulting in significant injury to the resident.

This area of non-compliance was identified during CIS Inspection log #022895-17 conducted concurrently with the RQI. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 30th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Daria Trzos

Service Area Office / Bureau régional de services : Central West Service Area Office