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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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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 30, 2018	2018_723606_0016	016555-18	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 30, 31, August 1, 2, and 3, 2018.

The following intakes were completed:
Complaint (CO):
Intake #016555-18 regarding an allegation of neglect/improper care of a resident after a fall.
Critical Incidents (CI):
Intake # 007990-18 CI #2124-000017-18 regarding a resident fall and change in condition;
Intake #007091-18 CI #2124-000014-18 regarding a resident fall resulting in a fractured rib; and
Intake 011543-18 CI #2124-000023-18 regarding a resident sustaining a fracture of the left femur of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Physician, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) 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:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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. 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, (b) was complied with.

In Accordance 30 (1) O. Reg. 79/10 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 section 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 and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy entitled, "Falls Prevention Program, Quality Management, Fall Risk Assessment Policy", revised April 2010, directs the registered staff that when a resident has fallen the SDM must be notified of the fall incident immediately.

Review of a Critical Incident (CI) reported resident #001 had a fall, was transferred to the hospital, and diagnosed with a medical condition.

Interview with resident #001's Substitute Decision Maker (SDM) alleged that the registered staff did not notify them of the resident's fall and found out about the resident's condition when they had arrived at the home. They told the Long Term Care Homes (LTCH) inspector that had they been notified of the resident's fall after it happened, the SDM said they would have made it a point to get to the home immediately.

Interview with Registered Nurse (RN) #103 stated that they did not call the SDM after the resident had fallen because it was during a meal service and that they had to be in the dining room to supervise the residents. RN #103 added that the resident's SDM arrived at the home while the resident was eating and was informed during that time.

Interview with the Director of Nursing (DON) acknowledged that it is the home's expectation that the staff follow the home's Falls Prevention Program Policy and Procedure and that when a resident has fallen, their SDM must be notified immediately. [s. 8. (1) (a),s. 8. (1) (b)]

2. A) Review of a complaint reported an allegation of neglect and improper care of resident #001 after the resident had a fall in 2018.

Interview with resident #001's SDM alleged that the registered staff did not assess the resident properly and therefore delayed the resident's transfer to the hospital for further treatment. The SDM told the LTCH Inspector that the resident was diagnosed with a medical condition which they stated may have caused the resident to fall.

Review of resident #001's progress notes stated the resident, while attending to a task, resident #001 lost their balance and fell to the floor. Further review of the progress notes revealed that on assessment, the resident was awake, oriented to person, place and situation, denied pain, hand grasps were equal and strong, pupil size and reactions to stimuli was brisk. The resident was assessed as having normal range of motion to all extremities and was observed to have no visible injury. Further review of the progress notes stated the SDM of resident #001 arrived at the home and informed the staff that they observed that resident #001 was not looking well and requested the resident to be transferred to the hospital. The resident was transferred to the hospital.

Review of the home's policy and procedure entitled, "Head Injury Routine", Index I.D. RCS #-35, original date December 2000, stated that the resident will be closely observed and assessed and vital signs will be monitored according to established guidelines subsequent to a head injury or a suspected head injury. Vital Signs to be checked and recorded 72 hours (hrs) on the Neurological Flow Sheet as follows: every 15 minutes for one hour; every 30 minutes for two hours, every hour for five hours, every four hours for 16 hours, and every eight hours for 48 hours.

Review of resident #001's Neurological Flow Sheet stated the resident was assessed two times and that the resident was not assessed after.

Interviews with Registered Nurse (RN) #103 and Registered Practical Nurse (RPN) #102 stated that resident #001 was assessed two times and was not assessed after according to the Neurological Flow Sheet. The registered staff said that they did not obtain the resident's neurological and vital signs status indicated on the Neurological Flow Sheet because the resident was eating and the resident looked stable to them.

Interview with the Medical Director (MD) stated that when a resident has fallen, registered staff are to obtain vital signs and complete neurological checks to monitor any changes in the resident's status according to the Neurological Flow Sheet.

B) Review of a CI reported resident #002 had a fall and was transferred to the hospital and was diagnosed with a medical condition.

Review of resident #002's progress notes stated the resident had fell due to a medical condition. The progress notes stated the resident was assessed and was observed with a head injury. The physician and the resident's SDM was notified and the resident was transferred to the hospital for further assessment and returned the same day. Further review of the progress notes stated that a Head Injury Routine (HIR) was initiated to continue to monitor the resident. However, review of resident #002's Neurological Flow Sheet revealed that the resident's neurological status and vital signs on two identified dates were not completed fully.

C) Review of resident #003's progress notes indicated that resident #003 had a fall in their room. The resident was assessed and a head to toe assessment was completed.

Review of resident #003 Neurological Flow Sheet stated the resident's vital signs and neurological status was not completed.

Interview with the DON stated that it the expectation that when a resident has fallen, the registered staff must initiate and complete a Neurological Flow Sheet as indicated in the policy to monitor any changes in their vitals and neurological status. [s. 8. (1) (a),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 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, (b) was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the record of every former resident of the home was retained by the licensee for at least ten years after the resident was discharged from the home.

Review of resident #004's progress notes stated the resident had a fall and that the resident told the staff they hit their head. The resident was assessed and a HIR was initiated. Further review of the progress notes indicated the resident was recently discharged from the home.

Review of resident #004's discharge files did not include the resident's "Neurological Flow Sheet" for the fall incident.

Interview with the DON stated could not locate that the neurological flow sheet for resident #004's fall and acknowledged the document should have been in the resident's discharge file and was not. [s. 233. (1)]

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Issued on this 11th day of September, 2018

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

Original report signed by the inspector.