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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2019	2019_727695_0006	007526-18, 008700-18, 012445-18, 012575-18, 013887-18, 015268-18, 016428-18, 017609-18, 020171-18, 030246-18, 031591-18, 005385-19	Critical Incident System

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

FARAH_ KHAN (695), KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 19, 20, 21, and 22, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Log #007526-18, related to concerns of privacy and alleged neglect
Log #008700-18, related to alleged neglect of a resident
Log #012575-18, related to staff to resident alleged abuse
Log #013887-18, related to a fall with injury
Log #015268-18, related to allegations of neglect and care of a resident
Log #016428-18, related to a missing resident
Log #017609-18, related to responsive behaviours
Log #020171-18, related to a fall with injury
Log #030246-18, related to a fall with injury
Log #031591-18, related to a fall with injury
Log #005385-19, related to staff to resident alleged abuse

During the course of the inspection, the following Follow Up intake was inspected:
Log #012445-18, related to transferring and positioning

During the course of the inspection the inspectors observed the provision of care and services, reviewed relevant documents including: clinical records, policies and procedures, annual evaluation, training records, and meeting minutes, and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), Environmental Manager, registered practical nurses (RPN), LTC Social Worker, Physiotherapist (PT), registered nurses (RN), Behavioural Support Manager, the Director of Care (DOC),and the Executive Director.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2018_543561_0005	743

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	Légende 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. 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 residents are not neglected by the licensee or staff.

In subsection 5 of the Regulation, neglect means, the failure to provide a resident with the 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.

The Ministry of Health and Long Term Care (MOHLTC) was forwarded a Critical Incident (CI), related to a resident who was allegedly left in a certain place for a certain number of hours, in a certain condition that was not supported by their plan of care.

A record review was completed and documentation from a specific date in 2018, reported that in the afternoon, resident #008 called out into the hallway asking for the Behavior Support Manager (BSO) #121 to assist them. The resident was upset that they had been left in a certain place since early that morning and was found in a position that was not supported by their plan of care.

An interview with the BSO Manager #121 confirmed that the resident was upset and had been left for a certain number of hours in that specific position. BSO Manager #121 and Registered Nurse (RN) #118 confirmed that the resident was found in a position that was not supported by their plan of care.

According to resident #008's care plan, they required assistance for most their activities of daily living. The care plan also documented that one of the resident's behavioral triggers was being in the specific position that they were found. An interview with the resident confirmed that they did not like to be in that position.

In the home's investigation documents, PSW #123 acknowledged that they placed the resident in that position.

Both the BSO Manager #121 and RN #118 said that that on a specific date, resident #008 was not provided the care, services or assistance required for their health and well-being.

The licensee failed to ensure that resident #008 was not neglected by the licensee or staff; when they did not follow the residents plan of care to meet their needs during specific number of consecutive hours on a specific date.

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 the licensee or staff, to be implemented voluntarily.

Issued on this 28th day of March, 2019

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

Original report signed by the inspector.