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 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_0007	021237-18, 023358-18, 024930-18, 000085-19	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

FARAH_ KHAN (695), KIYOMI KORNETSKY (743)

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): 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 Complaint intakes were inspected:
Log #021237-18, related to continence care, dining, falls prevention, medication management concerns, and more
Log #023358-18, related to personal care and continence care concerns
Log #024930-18, related to personal care concerns
Log #000085-19, related to pain management, continence care and falls prevention concerns

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 - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 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	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. 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).

Findings/Faits saillants :

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

Resident #002 had a history of pain.

According to the physician's orders, resident #002 was to have monthly pain assessments conducted.

A review of the resident's monthly pain assessments revealed that in a particular month in 2019, it was not completed.

According to RPN #125, the Pain Lead, residents who were on pain medication were expected to have a monthly pain assessment. It allowed the registered staff to review the last month of medication use, including breakthrough medication, and identify any trends or patterns. As a result, they may contact the physician or identify whether additional pain interventions were required.

The Pain lead confirmed that the monthly pain assessment was not completed for the particular month in 2019 as specified in the plan of care for resident #002.

The licensee has failed to ensure that the pain assessment set out in the plan of care was completed for resident #002 as specified in the plan.

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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the home took immediate action to deal with pests.

A complaint was received regarding cockroaches in the home.

On a specific date at a specific time in 2019, the Inspector and RPN #111 observed a cockroach in the hallway near a particular room. The RPN acknowledged that this was a cockroach. The RPN explained that the process was to inform maintenance through documenting the information in their computer system when a cockroach is found.

The Environmental Manager stated that when a cockroach was found, staff were expected to report it to them through their maintenance computer system. The Environmental Manager explained that once they see the report the following morning, they would contact Pest Control immediately.

The home's Pest Control policy directed staff to record the location, number and description of all pests/rodents sighted. It also stated that the home would take prompt action to eliminate any infestation detected.

A certain number of days after the cockroach was observed , the Inspector and the Environmental Manager reviewed the documentation together over the past few days and found there was no documentation of the cockroach observed on that specific date by the Inspector and RPN #111. They confirmed that Pest Control was not contacted and had not visited since.

The licensee has failed to ensure that the home took immediate action to deal with cockroaches.

WN #3: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Resident #002 had a history of pain in to a particular area of their body.

According to the physician orders, resident #002 was prescribed two medications. One was to be given twice daily at certain timings and the other was to be given as needed.

On a particular date, the resident experienced pain. The resident's pain was expressed as high according to the Electronic – Medication Administration Record (E-MAR), and there were pain interventions administered. The progress note from later that date, stated that the resident was assessed at a particular time and that they continued to be in pain. RPN #104 documented that they administered medication that was not due until later that day to the resident.

RPN #104 stated they administered medication that was ordered twice daily and they acknowledged that it was not due to be applied until later that day. They also acknowledged knowing that the other medication was to be given when needed.

In an interview with RPN #125, the progress note was reviewed and they acknowledged that the other medication should have been given at that time.

The licensee has failed to ensure that prescribed medication was administered to resident #002 in accordance with the directions for use specified by the prescriber.

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.