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

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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
Oct 2, 2017	2017_575214_0014	016388-17	Complaint

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

ANSON PLACE CARE CENTRE
85 Main Street North Hagersville ON N0A 1H0

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

CATHY FEDIASH (214), AILEEN GRABA (682)

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): August 23, 24, 25, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Registered staff; Personal Support Workers (PSW); Health Care Aides (HCAs) and residents. During the course of the inspection, the Inspectors reviewed resident clinical records; reviewed policies and procedures; reviewed the home's complaints binder and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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

- **3 WN(s)**
- **2 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 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).

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 :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of resident #001's clinical record indicated that they had been diagnosed and treated for six identified diagnoses in 2016 and three identified diagnoses in 2017. An interview with the DOC confirmed that the resident had a chronic history of the identified diagnoses.

A review of the resident's current written plan of care had not contained any information regarding the resident's history of the chronic identified diagnoses, including interventions to minimize and prevent further diagnoses.

An interview with the DOC confirmed that no written plan of care was in place that set out the planned care for resident #001 in relation to the management of their chronic history of the identified diagnoses.

B) A complaint that was received by a family member of resident #001, indicated that the resident received assistance with an identified activity of daily living (ADL), using identified equipment and that a portion of the identified equipment was used in an identified manner.

On an identified date, front line nursing staff #100 and #102 were observed to provide care to resident #001. An interview with the staff confirmed that identified equipment was used in an identified manner and that they had been told that this was alright to do.

An interview with the DOC confirmed that the Physiotherapist (PT) assesses the use of the identified equipment for the residents in the home and that the identified equipment was to be used in the identified manner for resident #001 due to identified reasons.

A review of the resident's clinical records, including the current written plan of care had not contained any information about the use of the identified equipment in the identified manner; had not identified the type of equipment to be used or the reason for the identified use.

A review of the resident's written plan of care on an identified date, indicated that the resident's plan of care for the identified ADL had been revised on the same date, which was during this inspection, to include the use of an identified type of equipment in the identified manner.

An interview with the DOC confirmed that prior to this identified date, resident #001's written plan of care had not set out the planned care for the resident in relation to the type(s) of equipment used; the positioning of the equipment and the reason(s) for this intervention.

C) An interview with front line nursing staff #018 on an identified date, confirmed that resident #005 was assisted with an identified ADL that included the use of identified equipment and that a portion of this equipment was to be used in an identified manner and that this intervention had been in place for some time.

A review of resident #005's written plan of care for an identified ADL and dated with an identified created date, indicated that the resident required two person total assistance to complete the identified ADL. No interventions were identified that included the type of equipment to be used; the manner in which to use the identified equipment and the reason for using the equipment in the manner identified.

This intervention was also noted to have a revision date created the day prior; however, no revisions to the plan were able to be seen. A review of a report in Point Click Care (PCC), titled, Care Plan History for the resident's identified ADL focus indicated that two days prior, the resident's written plan of care had been revised to include the type of equipment to be used and the manner in which to use the identified equipment.

An interview with the RAI Coordinator confirmed that for some time, resident #005 had been assisted with the identified ADL using specified equipment and that a portion of this

equipment was able to be used in an identified manner. The DOC confirmed that the written plan of care had not set out the planned care for the resident in relation to the type(s) of equipment to be used and the identified manner in which to use the equipment until their plan was updated on an identified date, which had occurred during this inspection. [s. 6. (1) (a)]

2. 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 review of resident #001's clinical record and confirmed by the DOC, indicated that the resident had an identified chronic history of a specified diagnoses. A review of resident #001's current written plan of care indicated that the resident used an identified device that was to be changed every month and when needed (PRN). A review of the resident's electronic physician's orders indicated on a specified date to change the identified device monthly, every 30 days and PRN. A review of the electronic Treatment Administration Record (e-TAR) for an identified period of three months, indicated that on a specified date, the resident's identified device was documented as being changed. A review of the e-TAR indicated that 31 days later, a code of 9 had been documented, indicating Other/ See Nurse Notes. A review of the resident's progress notes for an identified period of 18 days, indicated that no nurse's notes had been documented regarding the reason for documenting a code of 9 and whether or not the resident's identified device had been changed.

An interview with staff #158 confirmed that the resident had refused to have their identified device changed on the identified date that a code 9 was documented on the e-TAR and that documentation placed in the resident's progress notes had not remained as the home was experiencing problems with their Point Click Care (PCC) documentation system. The staff member confirmed that they had documented this information on the 24 Hour Shift Report. A review of this document on the identified date, indicated that this information had been documented on this form indicating the resident's refusal and for day shift the following day to change the identified device. Documentation on the shift report for the following day, indicated that documentation by the evening shift indicated that the resident needed their device changed. Documentation on the shift report for the three days following, indicated that no documentation had been entered on the day, evening or night shift regarding the need to change the resident's identified device. Documentation on the shift report the following day, indicated that the day shift documented that the resident's identified device needed to be changed and the evening shift on this date documented that the resident's device

An interview with the DOC confirmed that the resident's identified device had not been changed for a period of 36 days and that the care set out in resident #001's plan of care in relation to the changing of their device, had not been provided to the resident as specified in their plan. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and to ensure 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of resident #001's current written plan of care indicated that the resident had an identified device that was to be changed every month and when needed (PRN). A review of the resident's electronic physician's orders indicated on a specified date to change the identified device monthly, every 30 days and PRN. A review of the e-TAR indicated that on a specified date, a code of 9 had been documented, indicating Other/

See Nurse Notes. A review of the resident's progress notes for an identified period of 18 days, indicated that no nurse's notes had been documented regarding the reason for documenting a code of 9 and whether or not the resident's identified device had been changed.

An interview with staff #158 confirmed that the resident had refused to have their identified device changed on the identified date that a code 9 was documented on the e-TAR and that documentation placed in the resident's progress notes had not remained as the home was experiencing problems with their PCC documentation system. The staff member confirmed that they had documented this information on the 24 Hour Shift Report. A review of this document on the identified date, indicated that this information had been documented on this form indicating the resident's refusal and for day shift the following day to change the identified device. Documentation on the shift report for the following day, indicated that documentation by the evening shift indicated that the resident needed their identified device changed. Documentation on the shift report for the three days following, indicated that no documentation had been entered on the day, evening or night shift regarding the need to change the identified device. Documentation on the shift report the following day, indicated that the day shift documented that the resident's identified device needed to be changed and the evening shift on this date documented that the resident's identified device had been changed.

A review of the resident's clinical record including the e-TAR, indicated that no documentation had been recorded in the resident's clinical record when their identified device had been changed on an identified date as per the 24 Hour Shift Report. An interview with the DOC confirmed that actions taken with respect to the changing of resident #001's identified device on a specified date, had not been documented in the resident's clinical record.

B) On an identified date, resident #001 was observed to have care provided by staff #100 and #102. During the provision of care, resident #001 verbalized that they were experiencing an identified symptom. Staff #102 asked the resident where the identified symptom was located and the resident responded with the identified location.

A review of the resident's progress notes on the same date, approximately two and a half hours later, had not identified any documentation of the resident's verbalized symptom. A review of the identified symptom under tasks in the Point of Care (POC) documentation system was observed to contain a follow up question that asked if the resident complained of this symptom. Documentation for this task on this date, indicated that

three entries at identified time periods, before and after the resident's verbalization of the identified symptom, had been entered for this date and all entries were documented as no, in response.

An interview with registered staff # 157 confirmed that they were looking after resident #001 this day and had not been informed of any verbalized complaints of the identified symptom, by the resident. Staff #157 confirmed that documentation of this symptom was to be entered in the POC task, which would create an alert for staff to follow up as well as was to be reported to registered staff. Staff #157 confirmed that the resident received routine prescribed intervention at the noon hour medication pass and confirmed following an assessment of the resident, that they were no longer verbalizing any further complaints of the identified symptom.

The DOC confirmed that when the specified symptom was identified by front line nursing staff, it was to be documented in the POC task and registered staff informed. The DOC confirmed that actions taken with respect to resident #001's verbalization of the identified symptom, had not been documented in the resident's clinical record.

C) On an identified date, a review of a report in PCC titled, Care Plan History, for resident #005, indicated that two days prior, the resident's care plan for an identified ADL had been updated to include the use of identified equipment and the manner in which to use the identified equipment. The report indicated that the day prior, the care plan was updated for the resident's identified ADL and no longer included the interventions of the manner in which to use the identified equipment.

An interview with the RAI Coordinator indicated that the resident had been assessed by the Physiotherapist (PT) on this date and that the identified equipment was no longer required to be used in the identified manner as the resident was now able to move more freely and was demonstrating a decrease in an identified behaviour. A review of the resident's clinical records had not identified the assessment completed by the PT. The RAI Coordinator confirmed that no assessment had been documented. The home contacted the PT, who was offsite and an assessment was documented in the resident's clinical records on this day that indicated that the resident no longer required the identified equipment.

The DOC confirmed that the above assessment conducted by the PT, had not been documented. [s. 30. (2)]

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 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

A review of resident #001's progress notes indicated that on an identified date, a family member of the resident had verbalized complaints regarding the care of the resident. The progress note indicated that the DOC and the Administrator were notified through electronic mail.

An interview with the DOC confirmed that the home did record complaints and concerns on a form titled, Client Service Response Form. A review of the forms indicated that the family member's complaints were documented on this form and dated the following day. A review of the form indicated that no documentation had been entered under the heading, Response to Complainant/Complainant Response. An interview with the DOC confirmed that a care conference had been scheduled approximately one month later with another family member who was the Power of Attorney (POA) to the resident, to discuss the resident's health status and any concerns. The DOC confirmed that a response acknowledging receipt of the complaint, had not been provided to the complainant within 10 business days. [s. 101. (1) 1.]

Issued on this 13th day of October, 2017

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

Original report signed by the inspector.