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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015	2015_210169_0014	H-003114-15	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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD STONEY CREEK ON L8E 5J2

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

YVONNE WALTON (169), CAROL POLCZ (156), JESSICA PALADINO (586), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 25, 26, 27, 28, 31, September 1, 2, 3, 8, 9, 10, 11, 14, 15, 16, 17, 2015

The following inspections were completed during this Resident Quality Inspection.

Critical Incidents: H-000463-14, 002557-14, 000266-14, 011697-15, 018312-15, 019797-15, 019800-15, 021791-15
Complaints: H-000622-14, 022096-15, 023969-15, 024000-15, 024006-15

During the course of the inspection, the inspector(s) spoke with Residents, Families, Residents Council, Family Council, Administrator, Director of Nursing and Personal Care (DOC), Business Manager, Programs Manager, Environmental Service Manager, Food Service Manager, RAI Coordinator, Staff Development Coordinator, Registered Dietitian, Dietary Aides, Registered Nursing Staff, Personal Support Workers (PSW), Housekeeping staff, Medical Director, Nurse Practitioner, Recreation Therapist, Physiotherapist, Physiotherapy aides and the Director of Operations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **7 VPC(s)**
- **5 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #005 was observed in bed with rails in use in August, 2015. Interview with the DOC confirmed the resident used bed rails while in bed for safety and mobility. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the DOC and RAI Coordinator on September 1, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) Resident #009 was observed in bed with rails in use in August 2015. Interview with a PSW and review of the written plan of care confirmed the resident used one bed rail while in bed for mobility. A review of the resident's written plan of care did not include an assessment of the bed rail being used. Interview with the DOC and RAI Coordinator on September 1, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place. [s. 15. (1) (a)]

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. 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 :

1. The licensee failed to provide Resident #001 with the treatment, care, services or assistance required for health,safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of Resident #001. Resident #001 was toileted by a PSW using the mechanical lift. Resident #001's plan of care indicated that the resident was to be supervised when they were taken to the washroom. Upon investigation by the licensee, it was confirmed that the PSW left the resident on the toilet unsupervised for at least 20 minutes.
The Administrator and DOC confirmed that the resident was neglected by the staff member. [s. 19. (1)]

2. The licensee has failed to ensure that all residents were protected from abuse and were not neglected by the licensee or staff. Resident #011 experienced emotional abuse from a PSW when requesting care. The resident pulled their call bell for assistance. The PSW responded by saying you will have to wait 30 minutes, because we are busy. The PSW also pointed their finger at the resident. During the home's investigation the PSW confirmed that they did argue with the resident and pointed their finger at the resident. [s. 19. (1)]

3. The licensee has failed to ensure that Resident #007 was protected from abuse by anyone and free from neglect by the licensee or staff in the home. On July 28, 2015 Resident #007 experienced verbal abuse from a PSW while receiving evening care. The plan of care for Resident #007 directed staff to assist the resident, however the resident was being assisted to the washroom and the PSW yelled at the resident. The resident received verbal communication of an intimidating nature. This was confirmed by documentation and staff interviews. [s. 19. (1)]

4. The licensee failed to ensure that resident #008 was not neglected by the licensee or

staff. A PSW was performing morning care on the resident and preparing to transfer the resident. The resident's plan of care indicated that the resident required two staff for assisting the resident with transferring. The resident received care by one PSW and fell. At no time did they call the RN to come in to assist or assess the resident until the evening shift. The resident was noted to be in pain upon movement and a pain assessment was not completed nor any pain medications were given to the resident. The resident sustained an injury. Interview with the Administrator confirmed the resident was neglected by the staff as the resident was not assessed immediately for injuries nor their pain managed. [s. 19. (1)]

5. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.
Resident #016 was overheard screaming that they did not want care. The resident was refusing and yelling out and the staff proceeded to perform the care. The resident was later seen in the hallway with tears in ther eyes. The Administrator confirmed on September 11, 2015 that was this incidence did occur. The licensee failed to protect the resident from abuse from the staff member who did not respect the residents right to refuse care.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.
Resident #002 reported to staff that another staff member had touched them in an inappropriate way. Documentation through a critical incident submitted by the home as well as interview with the staff who it was reported to, confirmed that the incident did occur. The incident was confirmed with the Administrator and the employee was terminated. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan was consistent with residents assessed care and safety needs.
The following were observations made during the inspection:

Observation on August 31, 2015 from 1720 hours to 2100 hours revealed assistance was not provided to residents who required it, according to their assessed need and plan of care. Resident #206 was assessed at high nutritional risk with significant swallowing issues including a high choking risk. The plan of care directed staff to provide constant assistance, supervision and encouragement throughout the entire meal, however this was not provided. The staff were observed intermittently sitting and feeding the resident, however they had other residents to feed also. The resident was very slow to swallow and as a result was not offered ther dessert. The PSW confirmed she was not able to provide dessert due to time constraints and she needed to assist many other residents also. There were two residents who received tray service in bed and they were completely assisted and supervised by family members. There were eight residents who required total assistance with meals in the dining room and there were two family members present to assist with their family members. The remaining residents were being assisted by two PSW's and a Recreational aide who was scheduled to be in the

dining room until 1730 hours, however had to remain in the dining room to provide assistance due to the number of residents who required assistance. This resulted in the evening program being offered approximately 30 minutes late. Upon arrival into the dining room at 1720 hours, the dietary aide was not in the dining room and the food was already removed. The residents were not offered seconds and desserts were waiting on a tray. The nursing staff were attempting to provide assistance to six residents who required it and to clear dishes and serve the desserts. The nursing staff were observed clearing the tables, including table cloths instead of assisting residents. The PSW's confirmed they are required to feed all residents, answer call bells, toilet residents who require it and completely clear tables. When a resident asked to go to the washroom or assistance to leave the dining room, the two PSW's would leave the residents they were assisting with eating to provide assistance to them. This resulted in a disrupted service and intermittent assistance which was not what several residents were assessed to receive Without the assistance of the family members who were feeding four residents in total, the staff would not be able to provide the assistance to the ten residents who require it. This was confirmed by the PSW's and families who were in attendance.

Observation during the evening shift on August 31, 2015 revealed Resident #236 was sitting in their wheelchair in their doorway looking down the hallway. They were asked why they was waiting and they identified they were waiting to go for their shower. The resident was observed sitting in the hallway for approximately 45 minutes and was told by the PSW they had to wait as the PSW needed to hand out the nourishments to other residents. The resident verbalized they probably won't want a shower by the time the nourishment cart is finished and the PSW is available to provide assistance to the shower.

Observation on the same evening shift, revealed Resident #235 was walking up and down the hallway for most of the evening. They required significant re-direction and the plan of care confirmed this assessed need. The staff were in resident rooms providing care and not always able to re-direct the resident resulting in arguments between residents who were being pushed against their will and putting the resident who was walking at risk of falling, also in their plans of care. Staff confirmed they can't be there to re-direct the resident as needed until they hear another resident calling for assistance, as they are providing care in resident rooms and need to get residents ready for bed and take them to the washroom.

Observation on the same evening, revealed Resident #237 was sitting in the lounge. They had an alarm and it activated often. The alarm activated several times over a

period of thirty minutes and staff came to assist the resident to sit down, however they were often leaving the residents they were providing care to, in order to attend to the chair alarm and resident. Staff confirmed they have to leave residents who they are providing care to, in order to assist other residents, according to their plans of care. They provide assistance according to risk and residents who are at risk of falling or getting injured get the care first. This results in residents having to wait to be toileted or assisted to bed. Observations made by the inspector confirmed this.

Observation on the same evening revealed Resident #206 had long finger nails with dark debris under the nail tips. When the resident's family came to visit, they confirmed they often come to visit their mother and their nails looks this way. Observations of several other residents confirmed finger nails were long and had dark debris under the nail tips. The policy of the home was to complete nail care when residents receive their baths, however residents are not getting their baths according to their plan of care and this was reflected in their lack of nail care. These observations were confirmed with the PSW's and families.

The following were discussions held during the inspection:

Two families identified they feel obligated to come during the supper meal to ensure their family member is fed their meals, including fluids. They identified staff are very busy during meals and have too many residents to provide assistance to. They have been observed by families feeding more than two residents at a time. They have observed residents not getting their meat cut up into pieces they can manage to feed themselves and the families have provided assistance to the residents to assist the staff.
The family member of the resident with the long and soiled fingernails identified they often come to visit the resident and see their finger nails in this condition.

Documentation during the review revealed the following:
An audit of the month of August 2015 was completed and it was noted the home worked short of nursing hours on eight different days. The staffing plan was reviewed with the Staff Development Coordinator. There is a staffing plan in place, however when staff are not available to work, the licensee is not able to replace shifts to meet the staffing plan and the assessed care needs of the residents' are not met.
For the pay period of July 23-August 19, the personal support worker hours were short 70 hours. During this period of time when staff was short, resident's did not receive their baths. An audit of five residents was completed and it was confirmed residents were not bathed on their scheduled bath day due to staff shortages. On August 6 , 2015 the

nursing hours were short 5.25 hours and two residents did not receive their bath. On August 7, 2015 the nursing hours were short 3.5 hours and two residents did not receive their bath. On August 8, 2015 the nursing hours were short 4 hours and two residents did not receive their baths. The PSW's identified they do not complete baths when they are short staffed and this was confirmed when the home was short staff for eight days in the month of August, 2015. Although the home does attempt to schedule staff for the following day, to do missed baths, the residents still did not receive their minimum of two baths a week. Due to the staffing shortages, the residents were not receiving their baths according to their plan of care. This was confirmed with the Staff Development Coordinator and documentation of the daily schedules including payroll balancing reports.
Documentation in the Family and Resident Council minutes also confirmed there are often times when the home is short staffed and the residents do not receive their baths. There is also documentation the residents must wait for call bells to be answered longer than usual and they do not receive timely to go to the washroom resulting in incontinence episodes. Family council minutes also mention the lack of bathing and nail care for residents due to staffing shortages.

The staffing plan does not meet the assessed care and safety needs of the residents. [s. 31. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 resident #008 were transferred using safe transferring and positioning techniques.

Resident #008 was assisted using a sit to stand lift with only one staff person while transferring resident from the bed to their wheelchair. Resident #008 was noted in their plan of care to require assistance of two staff members. The home conducted an investigation into the incident and determined that the staff member did not have two staff present for the entire process and the resident fell to the floor and sustained an injury. The home confirmed that the PSW did not follow the home's policy and manufacturer's instructions regarding mechanical lifts and safe transfer techniques resulting in significant harm to the resident. [s. 36.]

2. The plan of care for resident #006 indicated that staff were to provide two person extensive assistance for transfers. PSW's confirmed that the resident was not transferred with two staff as per the resident's plan of care. The staff failed to ensure that safe transferring techniques were used when assisting the resident. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
A bathing audit of Resident #206, #208, 209, 210, 211 and 002 was completed for the month of August 2015. The plans of care and the flow sheets were reviewed.

Resident #206 was scheduled to receive nine baths and received four.
Resident #208 was scheduled to receive nine baths and received three.
Resident #209 was scheduled to receive nine baths and received five.
Resident #210 was scheduled to receive nine baths and received six.
Resident #002 was scheduled to receive nine baths and received four.

The baths were missed and not by resident choice. The licensee attempted to schedule additional staff on the following day when the home worked short staffed, however the baths still were not completed at least twice a week. These missed baths were confirmed by documentation, resident interview and DOC. Nursing staff confirmed that when they are short staffed, they are directed to not complete baths. A review of the staffing plan was completed and is reflected in this report as non compliant. [s. 33.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

Resident #015 could be seen from the hallway and was not dressed. The resident was left in their brief and the sheets were pulled down to the bottom of the bed, indicating that the staff were in the process of getting the resident up for the day. When the staff member left the room they did not ensure the resident's privacy was maintained. [s. 3. (1) 8.]

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 ensures (1)8 every resident was afforded privacy in treatment and in caring for his or her personal needs and (1)11.ii give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
Resident #006 was noted to have an un-stageable wound as confirmed with registered staff during stage one of the inspection on August 26, 2015 and confirmed again on September 9, 2015. The current plan of care, however, indicated that the resident had a stage II wound.
The current Treatment Administration Record (TAR) indicated that staff were to provide a medicated ointment - apply to wound with each dressing change until clear. As confirmed with the DOC on September 9, 2015, the resident did not have a wound on the right side and the direction was to be for the resident's left side.
The plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the Power of Attorney for Personal Care (POA for PC) was notified of a fall Resident #13 had. The fall occurred and the resident did not sustain a significant injury but was experiencing some pain. The evening staff did not notify the POA for PC until the following day and denied the POA for PC an opportunity to participate fully in the development and implementation of the resident's plan of care, for example to send them to the hospital for assessment or to keep them at the home

and manage the pain. The clinical notes indicated the evening staff wrote a note endorsing the day staff to call the POA for PC the following day. This was confirmed by documentation and the DOC. The POA for PC did not have an opportunity to participate fully in the development of Resident #13 plan of care and the resident was ultimately sent to hospital where they were diagnosed with a fracture. [s. 6. (5)]

3. The licensee did not ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. In July 2015, twelve residents received Holter monitor applications and/or received echo-cardiograms. The resident's and substitute decision makers were not given an opportunity to participate fully in the development of the plan of care and confirmed they were not aware of the application of the diagnostic procedures or the reasons for them. This was confirmed by the Director of Care, Charge Nurse, lab and documentation. [s. 6. (5)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008's as specified in their plan.

Resident #008's plan of care directed staff to use two staff members for bed mobility and two staff members for the sit-to-stand lift. During a review of the resident's clinical record it indicated that on May 29, 2015, that only one staff member assisted the resident with their bed mobility and one staff member. The Administrator confirmed that the home did not follow the resident's plan of care. [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 that ensures there is a written plan of care for each resident that sets out,(c) clear directions to staff and others who provide direct care to the resident (5) the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and (7) 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 #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #206 received fingernail care, including the cutting of fingernails. On August 31, 2015 Resident #206 was observed with long fingernails and dark brown debris under them. This was confirmed by the PSW and family member. The policy of the home is to complete nail care with baths, however this resident did not receive baths according to her plan of care. See bathing non compliance. [s. 35. (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 that ensures each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #9: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.
Resident #006 was noted to have an unstageable wound on their left hand and did not receive 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. An assessment of the wound was not found in the clinical record as confirmed with the DOC on September 16, 2015. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.
Resident #006 was noted to have an unstageable wound. An assessment of the wound was not found in the clinical record and weekly skin assessments on the wound had not been completed as confirmed with the DOC and registered nursing staff on September 9, 2015. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that Resident #008 was repositioned every two hours or more frequently as required depending on the resident's condition. Resident #008 was observed in bed on August 31, 2015 at 1730 hours. The resident was in a semi-fowlers position. Staff identified they had already been fed their supper in bed and the resident remained in the same position until 2100 hours. The resident did not have any positioning aides to assist with support. Staff did not reposition them for over three hours and the resident was not able to reposition themselves. This was confirmed by PSW and direct observation. [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 that ensures (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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and (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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.
The plan of care for resident #006 indicated that the resident was frequently incontinent - at least one episode of incontinence daily and was on a toileting plan. The resident was not observed being taken to the toilet on September 10, 2015 between 1100-1200 hours. Interview with front line staff confirmed that the resident was not toileted on this day but was checked and changed once. Front line staff confirmed that the resident's individual toileting schedule was not followed as per the plan of care. [s. 51. (2) (b)]

2. The licensee has failed to ensure that Resident #7 had an individualized plan of care to promote and manage bowel and bladder continence based on an assessment, and that the plan implemented. Resident #7 required interventions to promote and manage their bladder continence. The documentation from the activity of daily living careplan used by PSW's identified the resident wears a pad during the day and a brief at night. Interview with the PSW caring for the resident revealed Resident #7 uses a brief during the day and a liner at night. The quarterly incontinence assessment identified the resident is continent when toileted regularly and the plan of care has a toileting schedule identified. Resident #7 was wearing briefs that are not included in their plan of care. This was confirmed by the RAI coordinator, family member and PSW. [s. 51. (2) (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 that ensures each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to the clinical record, resident #008 made verbal and nonverbal expressions of pain. The registered staff confirmed the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose, when the resident's pain was not relieved. [s. 52. (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 that ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all planned menu items were offered and available at each meal and snack.

The home's menu indicated that milk, water and juice were to be offered at lunch and dinner.
i. Observation of the lunch and dinner meal service on August 31, 2015, revealed that residents were only offered milk or water; no juice was offered.
ii. Interview with the DOC and RD confirmed that juice was not being offered as per the planned menu. [s. 71. (4)]

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 ensures all planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #13: 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 has failed to ensure that the home's policy and procedure for food temperatures was complied with.

The home's Food and Nutritional Services Manual policy titled "Serving Temperatures" (FNSMS140, section 7; last revised January 2013) indicated that the dietary aide was to take the temperatures of all food prior to serving and at the end of service and record temperatures on the temperature chart.
Resident #013 identified that their meal was cold after service on August 31, 2015. Review of the home's temperature record on August 31, 2015, revealed that the temperatures were not completed for the breakfast or lunch meals. The Food Service Manager confirmed that the temperatures were not completed and the staff were not following the home's policy for taking food temperatures. [s. 8. (1) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure alternatives to the use of a Personal Assistance Services Device (PASD) had been considered and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activities of living.

Resident #005 had two quarter rails applied to their bed. Review of the clinical record indicated that there was no assessment completed to determine if the bed rails were being used as a PASD. The home's DOC confirmed that there was no assessment completed and no alternatives had been considered and tried to assist the resident with the routine activities of living. [s. 33. (4) 1.]

2. The licensee has failed to ensure that the use of the PASD was approved by any person provided for in the regulation.

Review of the clinical records for residents #005 indicated there were no documented approvals for the use of the bed rails as a PASD. The home's DOC confirmed that there were no approvals obtained for the use of the PASD. [s. 33. (4) 3.]

3. The licensee failed to ensure that the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

Review of the clinical record indicated that resident #005 or their SDM did not provide consent for the use of bed rails as a PASD. The home's DOC confirmed there was no consent signed from the resident or their SDM for the use of bed rails as PASD. [s. 33. (4) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, (ii) height upon admission and annually thereafter.

The home did not ensure that all current resident's heights were taken annually as evidenced by review of the resident's clinical records. The Registered staff confirmed annual heights are not being done on all residents in the home. [s. 68. (2) (e) (ii)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to, preserve taste, nutritive value, appearance and food quality.

During the RQI inspection,family members voiced concerns about the juice offered at the home being watered down. Interview with a dietary aide confirmed that the juice was often watered down when it came from the kitchen. The dietary aide confirmed that the recipe for the juice was not being followed, affecting the taste and nutritive value of the fluid for the residents. [s. 72. (3) (a)]

2. The licensee has failed to ensure that there was a cleaning schedule for the food production areas, servery areas, and dish washing areas and that staff comply with this schedule. The nourishment carts were observed to be soiled and rusty on August 25, 27 and September 3, 2015. The steams tables used in both dining rooms were observed to be soiled with drips and food debris on August 27, 27 and September 3, 2015. The kitchen area was observed to have soiled floors, counters, dish mop area, dish area at a minimum on September 3, 2015. The cleaning schedules were available, however staff were not complying with them. All of the above observations were confirmed with the Director of Care. [s. 72. (7) (c)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily snack menu is communicated to residents. The daily and weekly meal and beverage menu was posted, however the snack menu was not posted. This was confirmed by the Food Service Manager and Director of Care. Observation of the menu confirmed the snack menu is not posted. [s. 73. (1) 1.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident. Observation on August 31, 2015 revealed there were no towels available in a resident room. The two residents who go to the washroom and requested to have towels available to hang in their washroom to dry their hands after toileting. The two residents identified they were directed to use paper towel to dry their hands. Interview with the Environmental Services Manager (ESM) confirmed paper towels are to be used by residents in the washrooms. Interview with PSW indicated they would not have enough towels if everyone had one in their washroom for use. Observation of the linen supply confirmed there was in insufficient supply of clean linen available in the home for use by residents. A discussion was held with the ESM, DOC and Administrator that resident must be provided towels when they are requesting them and should not be directed to use paper towels when they want a towel. [s. 89. (1) (b)]

WN #19: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes: a) the nature of each verbal or written complaint (b) the date the complaint was received (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant?

The licensee received a written letter of complaint outlining concerns related to the care of a resident. A response was not provided within 10 days of receipt of the complaint to the complainant. This was confirmed by documentation, staff interviews and the complainant. The MOH and the complainant had not received a response letter outlining the follow up actions required. This was confirmed by the licensee and the complainant. [s. 101. (2)]

2. The licensee has failed to ensure that a response was provided to a complainant and it was documented. A letter of complaint was sent to the home on July 19, 2014 and a response was not provided to the complainant. This was confirmed by the complainant and the Administrator. [s. 101. (2)]

Issued on this 20th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169), CAROL POLCZ (156), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2015_210169_0014
Log No. / Registre no:	H-003114-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 20, 2015
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	ORCHARD TERRACE CARE CENTRE 199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Agnes Jankowski

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.
The licensee shall ensure all residents using bed rails receive an assessment of his or her bed system and an evaluation in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The licensee shall ensure staff receive education on bed rail assessments.

Prepare and submit a plan to Yvonne.Walton@ontario.ca by November 27, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #005 was observed in bed with rails in use on August 22, 2015. Interview with the DOC confirmed the resident used bed rails while in bed for safety and mobility. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the DOC and RAI Coordinator on September 1, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) Resident #009 was observed in bed with rails in use on August 6, 2015. Interview with a PSW and review of the written plan of care confirmed the resident used one bed rail while in bed for mobility. A review of the resident's written plan of care did not include an assessment of the bed rail being used. Interview with the DOC and RAI Coordinator on September 1, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan the ensures all residents in the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The plan must include a training program related to residents rights, lifts and transferring techniques, following the plan of care, assessments when injuries are identified, pain management at the time of an injury, notification of Substitute Decision Makers where appropriate, documentation of relevant information where indicated.

Prepare and submit the plan to Yvonne.Walton@ontario.ca by November 27, 2015.

Grounds / Motifs :

1. The licensee failed to provide Resident #001 with the treatment, care, services or assistance required for health,safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of Resident #001. Resident #001 was toileted by a PSW using the mechanical lift. Resident #001's plan of care indicated that the resident was to be supervised when they were taken to the washroom. The failure to provide the resident with the care and assistance required, jeopardized the health and safety of the resident, putting them at risk of falling and potential injury. Upon investigation by the licensee, it was confirmed that the PSW left the resident unsupervised for at least 20 minutes while the PSW went for their break. The Administrator and DOC confirmed that the resident was neglected by the staff member.

The licensee has failed to ensure that Resident #007 was protected from abuse by anyone and free from neglect by the licensee or staff in the home. Resident #007 experienced verbal abuse from a PSW while receiving care. The plan of care for Resident #007 directed staff to assist the resident. The resident received verbal communication of an intimidating nature voice which diminished the resident's sense of well-being, dignity and self-worth by crying. This was confirmed by documentation and staff interviews.

The licensee failed to ensure that resident #008 was not neglected by the licensee or staff. A PSW was performing morning care on the resident and preparing to transfer the resident. The resident's plan of care indicated that the resident required two staff and only one was used and a fall occurred. At no time did they call the RN to come into assist or assess the resident.

The RN did go and assess the resident at approximately 1900 hours and noted that there was extensive bruising and swelling. The physician was called and treatment ordered.
The resident was noted to be in pain upon movement during the assessment, the RN on evening shift confirmed that a pain assessment was not completed nor any pain medications were given to the resident at this time. The RN on the night shift confirmed that when they were assessing the resident, the resident called out in pain. The RN at this time did not give the resident any pain medication nor completed a pain assessment. The RN on the day shift documented that the resident had severe pain. The resident was sent to the hospital and the resident sustained an injury.
Interview with the Administrator confirmed the resident was neglected by the staff as the resident was not assessed immediately for injuries.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Resident #002 reported to staff that another staff member had touched them in an inappropriate way. The resident experienced non-consensual touching and was not protected from abuse. The incident was confirmed with the Administrator and the employee was terminated.
(169)

2. The licensee has failed to ensure that all residents were protected from abuse and were not neglected by the licensee or staff.

Resident #011 reported to the DOC that there was an incident with a PSW. The resident stated that they pulled their call bell for help. The PSW responded by saying you will have to wait 30 minutes, because we are busy and they were pointing their finger at the resident. During the home's investigation the PSW confirmed that they did argue with the resident and pointed their finger at the resident. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the staffing plan identified by the home will be reviewed to ensure the staffing plan provides a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

The plan shall be submitted to Yvonne.Walton@ontario.ca by November 9, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan was consistent with residents assessed care and safety needs.
The following were observations made during the inspection:

Observation on August 31, 2015 from 1720 hours to 2100 hours revealed assistance was not provided to residents who required it, according to their assessed need and plan of care. Resident #206 was assessed at high

nutritional risk with significant swallowing issues including a high choking risk. The plan of care directed staff to provide constant assistance, supervision and encouragement throughout the entire meal, however this was not provided. The staff were observed intermittently sitting and feeding the resident, however they had other residents to feed also. The resident was very slow to swallow and as a result was not offered her dessert. The PSW confirmed she was not able to provide dessert due to time constraints and she needed to assist many other residents also. There were two residents who received tray service in bed and they were completely assisted and supervised by family members. There were eight residents who required total assistance with meals in the dining room and there were two family members present to assist with their family members. The remaining residents were being assisted by two PSW's and a Recreational aide who was scheduled to be in the dining room until 1730 hours, however had to remain in the dining room to provide assistance due to the number of residents who required assistance. This resulted in the evening program being offered approximately 30 minutes late. Upon arrival into the dining room at 1720 hours, the dietary aide was not in the dining room and the food was already removed. The residents were not offered seconds and desserts were waiting on a tray. The nursing staff were attempting to provide assistance to six residents who required it and to clear dishes and serve the desserts. The nursing staff were observed clearing the tables, including table cloths instead of assisting residents. The PSW's confirmed they are required to feed all residents, answer call bells, toilet residents who require it and completely clear tables. When a resident asked to go to the washroom or assistance to leave the dining room, the two PSW's would leave the residents they were assisting with eating to provide assistance to them. This resulted in a disrupted service and intermittent assistance which was not what several residents were assessed to receive Without the assistance of the family members who were feeding four residents in total, the staff would not be able to provide the assistance to the ten residents who require it. This was confirmed by the PSW's and families who were in attendance.

Observation during the evening shift on August 31, 2015 revealed Resident #236 was sitting in their wheelchair in their doorway looking down the hallway. They were asked why they was waiting and they identified they were waiting to go for their shower. The resident was observed sitting in the hallway for approximately 45 minutes and was told by the PSW they had to wait as the PSW needed to hand out the nourishments to other residents. The resident verbalized they probably won't want a shower by the time the nourishment cart

is finished and the PSW is available to provide her with assistance to the shower.

Observation on the same evening shift, revealed Resident #235 was walking up and down the hallway with their walker, for most of the evening. The resident walked directly along the handrail, as a guide, however whenever another resident was in their way, for example sitting in their wheelchair by the rail or a soiled linen hamper was in the hallway, the resident would become agitated and begin to push whatever was blocking their path. They required significant re-direction and the plan of care confirmed this assessed need. The staff were in resident rooms providing care and not always able to re-direct the resident resulting in arguments between residents who were being pushed against their will and putting the resident who was walking at risk of falling, also in their plans of care. Staff confirmed they can't be there to re-direct her as needed until they hear another resident calling for assistance, as they are providing care in resident rooms and need to get residents ready for bed and take them to the washroom.

Observation on the same evening, revealed Resident #237 was sitting in the lounge at the entrance to the home. They had a chair alarm on their seat and it activated often, indicating the resident was attempting to stand up and putting themselves at risk for falling. The alarm activated several times over a period of thirty minutes and staff came to assist the resident to sit down, however they were often leaving the residents they were providing care to, in order to attend to the chair alarm and resident. Staff confirmed they have to leave residents who they are providing care to, in order to assist other residents, according to their plans of care. They provide assistance according to risk and residents who are at risk of falling or getting injured get the care first. This results in residents having to wait to be toileted or assisted to bed. Observations made by the inspector confirmed this.

Observation on the same evening revealed Resident #206 had long finger nails with dark debris under the nail tips. When the resident's family came to visit, they confirmed they often come to visit their mother and their nails looks this way. Observations of several other residents confirmed finger nails were long and had dark debris under the nail tips. The policy of the home was to complete nail care when residents receive their baths, however residents are not getting their baths according to their plan of care and this was reflected in their lack of nail care. These observations were confirmed with the PSW's and families.

The following were discussions held during the inspection:

Two families identified they feel obligated to come during the supper meal to ensure their family member is fed their meals, including fluids. They identified staff are very busy during meals and have too many residents to provide assistance to. They have been observed by families feeding more than two residents at a time. They have observed residents not getting their meat cut up into pieces they can manage to feed themselves and the families have provided assistance to the residents to assist the staff.
The family member of the resident with the long and soiled fingernails identified they often come to visit the resident and see their finger nails in this condition.

Documentation during the review revealed the following:

An audit of the month of August 2015 was completed and it was noted the home worked short of nursing hours on eight different days. The staffing plan was reviewed with the Staff Development Coordinator. There is a staffing plan in place, however when staff are not available to work, the licensee is not able to replace shifts to meet the staffing plan and the assessed care needs of the residents' are not met.

For the pay period of July 23-August 19, the personal support worker hours were short 70 hours. During this period of time when staff was short, resident's did not receive their baths. An audit of five residents was completed and it was confirmed residents were not bathed on their scheduled bath day due to staff shortages. On August 6 , 2015 the nursing hours were short 5.25 hours and two residents did not receive their bath. On August 7, 2015 the nursing hours were short 3.5 hours and two residents did not receive their bath. On August 8, 2015 the nursing hours were short 4 hours and two residents did not receive their baths. The PSW's identified they do not complete baths when they are short staffed and this was confirmed when the home was short staff for eight days in the month of August, 2015. Although the home does attempt to schedule staff for the following day, to do missed baths, the residents still did not receive their minimum of two baths a week. Due to the staffing shortages, the residents were not receiving their baths according to their plan of care. This was confirmed with the Staff Development Coordinator and documentation of the daily schedules including payroll balancing reports.

Documentation in the Family and Resident Council minutes also confirmed there are often times when the home is short staffed and the residents do not receive their baths. There is also documentation the residents must wait for call bells to be answered longer than usual and they do not receive timely to go to the washroom resulting in incontinence episodes. Family council minutes also mention the lack of bathing and nail care for residents due to staffing shortages.

The staffing plan does not meet the assessed care and safety needs of the residents. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2015

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

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 shall prepare, submit and implement a plan that ensures staff use safe transferring and positioning devices or techniques when assisting residents. The plans of care for all residents related to transferring and positioning shall be followed, including Resident #006 and #008.

The plan must include training for the staff regarding each residents plan of care and the directions for safe transferring of residents.

Prepare and submit the plan to Yvonne.Walton@ontario.ca by November 27, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that resident #008 were transferred using safe transferring and positioning techniques.

On May 29, 2015, resident #008 was assisted using a sit to stand lift with only one staff person while transferring resident from the bed to their wheelchair. Resident #008 was noted in their plan of care to require assistance of two staff members. The home conducted an investigation into the incident and determined that the staff member did not have two staff present for the entire process and the resident fell to the floor and sustained an injury. The home confirmed that the PSW did not follow the home's policy and manufacturer's instructions regarding mechanical lifts and safe transfer techniques resulting in significant harm to the resident.
The plan of care for resident #006 indicated that staff were to provide two person extensive assistance for transfers. PSW's confirmed that the resident was not transferred with two staff as per the resident's plan of care. The staff failed to ensure that safe transferring techniques were used when assisting the resident. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2015

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. Bathing

Order / Ordre :

The licensee shall ensure all residents receive a minimum of two baths a week, by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. The bathing shall include nail care according to the home's policy of completing nail care with bathing.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
A bathing audit of Resident #206, #208, 209, 210, 211 and 002 was completed for the month of August 2015. The plans of care and the flow sheets were reviewed.

Resident #206 was scheduled to receive nine baths and received four.
Resident #208 was scheduled to receive nine baths and received three.
Resident #209 was scheduled to receive nine baths and received five.
Resident #210 was scheduled to receive nine baths and received six.
Resident #002 was scheduled to receive nine baths and received four.
The baths were missed and not by resident choice. The licensee attempted to schedule additional staff on the following day when the home worked short staffed, however the baths still were not completed at least twice a week. These missed baths were confirmed by documentation, resident interview and DOC. Nursing staff confirmed that when they are short staffed, they are directed to not complete baths. A review of the staffing plan was completed and is reflected in this report as non compliant. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

Service Area Office /
Bureau régional de services : Hamilton Service Area Office