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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 2, 2017 | 2017_570528_0012 | 006384-17 | 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

CYNTHIA DITOMASSO (528), IRENE SCHMIDT (510a), LEAH CURLE (585)

## 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): March 24, 28, 29, 30, 31 and April 4, 5, 6, 7, 2017**

**This inspection was completed concurrently with:**
**i. Complaint inspection log #'s: 022543-16 related to continence care, 023379-16 related to resident care, 026089-16 and 005980-17 related to allegation of neglect, 034102-16 and 006065-17 and 006543-7 related to medication management, 002615-17 related to hospitalization and change in condition**
**ii. Critical Incident System log #'s: 022377-16 and 027467-16 allegations of neglect, 030751-16 unexpected death, 032497-16 staff to resident abuse allegations, 033931-16 visitor to resident abuse allegations, 003439-17 medication incident**
**iii. Follow up Inspection log #'s: 033474-16 related to significant weight changes, 033476-16 related to documentation, 033477-16 related to qualifications of the Environmental Services Lead, 034408-16 related to abuse, 034409-16 related to responsive behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Interim Administration, the Director of Nursing and Personal Care (DON), the Registered Dietitian (RD), the Physician, the Quality/Business Manager, the Programs Manager, the Environmental Services Manager (ESM) and Staff Development Coordinator, the Food Services Manager (FSM), the Resident Assessment Instrument (RAI) Coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides, maintenance, residents and families.**

**During the course of the inspection, the inspectors also toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to, clinical health records, policies and procedures, investigation notes, medication incident reports, staff schedules, staff communication books, and meeting minutes.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Trust Accounts**

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2016_205129_0011 | 528 |
| O.Reg 79/10 s. 30. (2) | CO #004 | 2016_215123_0009 | 528 |
| O.Reg 79/10 s. 69. | CO #002 | 2016_215123_0009 | 585 |
| O.Reg 79/10 s. 92. (2) | CO #005 | 2016_215123_0009 | 528 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

A. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #015 was admitted to the home in late 2016, at which time a responsive behavior assessment was completed and revealed that the resident had responsive behaviours with triggers identified. The assessment noted the resident to be at risk and that the care plan had been updated.
i. Review of the MDS assessment completed December 2016, identified a change in mood and behaviours. Further review of the clinical record revealed that the resident continued to demonstrated responsive behaviours in 2017.
Ii. In spite of this identified change in mood and behaviors, a responsive behaviors assessment was not completed for resident #015 in December 2016, and new interventions were not identified. Review of the clinical record for resident #015 revealed that in February 2017, the resident demonstrated ongoing behaviours. However, a responsive behaviors assessment was not completed until the following month. Review of this assessment revealed that the behaviors identified in the clinical record in February 2017, were not reflected in the assessment and in fact, it contained the same information as the December 2016, responsive behavior assessment.
iii. The Home's policy titled Responsive Behavior Philosophy, under 'Behavioral Management and Responsive Behavior Philosophy and Assessment', the number two under procedure, directed that the responsive behavior assessment occurs quarterly and

if the resident has a significant change; and under 'Outcome', stated that all residents with responsive behaviors would be assessed, interventions put in place and referrals to external resources accessed.
iv. Review of the clinical record revealed that, in spite of the documented ongoing change in behaviors between 2016 and 2017, there were no additional interventions identified or implemented for the management of behaviors for resident #015 until March 2017, as confirmed by the DOC and the Quality/Business Manager.
v. The DOC and QI/Business Manager confirmed resident #015 did not receive a quarterly responsive behavior assessment in December 2016, in spite of a change in behaviors identified in MDS, nor did they receive a responsive behavior assessment in February 2017, when behaviors continued to be demonstrated. The DOC also confirmed the document the home referred to as the care plan was not updated with additional interventions until March 2017, subsequent to this inspection being conducted.

The licensee did not ensure strategies were developed and implemented when resident #015 demonstrated a decline in behaviors over a five month period. Actions were not taken by the home to respond to the needs of resident #015, including assessments, reassessments and interventions, when the resident continued to demonstrate a change in behaviors, resulting in a potential for actual harm to resident #015 and co-residents.

B. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

In December 2016, dementia observational system (DOS) charting was initiated for an identified resident and identified event; however, review of their clinical record between December 2016 to February 2017, revealed DOS charting was not completed every 30 minutes on 44 out of 61 days. Interview with PSW # 119 who reported the resident's planned care was for staff to monitor and document their behaviours every 30 minutes. The Administrator reported in an interview that the resident had responsive behaviours and staff were to complete the DOS charting; however, confirmed the resident's responses to the intervention to receive DOS charting was not implemented.

***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 O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The home's "Algorithm for Management of Hypoglycemia" undated, identified that if a resident had a blood glucose of less than 4.0 millimoles per litre (mmol/L) or was showing signs and symptoms of hypoglycemia and was conscious, to complete the following:
i. give 15 grams of carbohydrate
ii. retest blood glucose in 15 minutes
iii. if next meal is more than one hours away give protein plus carbohydrate snack
iv. if next meal is less than an hour away set up meal as soon as possible

A. The plan of care for resident #090 identified that the resident was on a combination of medications and staff were checking capillary blood glucose (CBG).

i. On an identified day in July 2016, the CBG was documented below 4.0 mmol/L. Registered staff documented they provided the resident with interventions; but there was no documentation that the CBG was rechecked after the intervention was provided.
ii. On an identified day in November 2016, the CBG was documented less than 4.0 mmol/L. Registered staff documented that medication was held; however, did not indicate if 15 grams of carbohydrate was given or the CBG was rechecked in 15 minutes.
iii. On an identified day in December 2016, the CBG was documented as less than 4.0 mmol/L. Registered staff documented that an intervention was implemented, but there was no recheck of the CBG completed.

B. The plan of care for resident #034 identified that the resident was on a combination of medication and staff were checking the resident's CBG.
i. On an identified day in December 2016, the CBG was documented as less than 4.0 mmol/L. No further action was noted.
ii. On an identified day in January 2016, the CBG was documented was less than 4.0 mmol/L. Documentation noted the registered staff rechecked the CBG an hour later, at which time, it was greater than 4.0 mmol/L.
iii. On an identified day in January 2017, the CBG was less than 4.0 mmol/L. Staff did not document interventions or recheck until over an hour later, and the CBG was greater than 4.0 mmol/L.
iv. On an identified day in February 2017, the CBG was 4.0 mmol/L. Staff did not document interventions or a recheck until over an hour later, which stated the CBG was greater than 4.0 mmol/L.

C. The plan of care for resident #016 identified that the resident was taking a combination of medications, as well as a corticosteroid, and staff were monitoring the resident's CBG.
i. On an identified day in January 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented interventions were given but there was no recheck of the resident's CBG completed.
ii. On an identified day in March 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented that the interventions were implemented, but did not specify whether the resident received a carbohydrate or whether the CBG was rechecked.
iii. On an identified day in March 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented that interventions were implemented; however, no CBG recheck was completed.

Interview with the DON confirmed that staff were required to recheck the CBG after 15

minutes of providing a carbohydrate, as outlined in the protocol; however, in the above examples, the registered staff did not follow the home's hypoglycemia protocol in relation to documenting what intervention was provided to a resident with a CBG of less than 4.0 mmol/L and rechecking the resident's blood sugar within 15 minutes for residents # 090 #037 and #016 . (528)

***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 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 clear directions to staff and others who provided direct care to the resident.

In January 2017, resident #090 had a symptom that required the registered staff to administered a medication as per the resident's medical directive, which stated to provide the medication as needed and call physician if no improvement in 24 hours. Two days later, the physician assessed the resident as having the symptom, no new orders were given; however, the electronic medication administration record (eMARS) were updated to indicate that the medical directive was to be given daily . Interview with RN #120 identified that they entered the medical directive order on the eMARS incorrectly. As a

result, interview with RN #110 confirmed that they assumed the physician ordered the medication to be given once a day when they saw the resident that week, and therefore, did not call when the symptoms did not improve. The plan of care was not clear when the medical directive was entered incorrectly into the eMARs. (528)

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. In December 2016, resident #090 had a fall resulting in an injury. Review of the plan of care identified that the resident was at risk for falls and was not to be left unattended when toileted. Interview with PSW #119 identified that the resident was left unattended when the staff left the room to assist the second resident. When they returned the resident had fallen. Interview with the DO confirmed that the two PSW staff did not attend to the resident at all times when toileted, which was required in the written plan of care. (528)

B. A medical directive for resident #090 stated that a medication could be given every four to six hours as needed for a symptom and to call the physician if no improvement within 24 hours.
In January 2017, resident #090 had a a symptom that required a medication to be given per the medical directive. The physician assessed the resident the following day and noted the symptom from the day prior and no new orders were received. Review of the progress notes identified that the resident had ongoing symptoms and medication was administered with good effect up to four days after the physician assessed the resident. Interview with regular staff RN #110 and #120 and the Interim Administrator confirmed that after the physician assessed the resident, they continued to have the ongoing symptom; however, the physician was not notified, as required in the medical directive. (528)

C. The plan of care for resident #090 identified that the resident had multiple co-morbidities and was eligible to use outside services if they were with a support person.

On an identified day in August 2016, the resident left the home without a support person. Interview with staff #122 and medical professionals from the destination confirmed that the resident reached the destination safely and returned less than two hours later with no harm to their health or well being. Staff #122 confirmed that the resident should not have left the home without a support person. Interview with the DON and Interim Administrator confirmed that the resident was provided with a support person when they

left the home in August 2016. (528)

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A. The plan of care for resident #090 identified that on an identified day in June 2016, the resident received the wrong dosage of medication at the wrong time. As a result of the medication incident, the resident required increased monitoring but no harm occurred. Interview with the DON confirmed that in June 2016, resident #090 received the incorrect dose of medication. (528)

B. In February, 2017, a change in medications were ordered by the physician. Registered staff #116 discontinued the incorrect medication for resident #039, which was rechecked by registered staff #110. Review of the clinical health record revealed that the resident did not receive the medication for four days and as a result had symptoms that required treatment at the hospital. Interview with the DOC confirmed that the medication was discontinued in error and was not administered to resident #039 in accordance with the directions for use specified by the prescriber, resulting in their transfer to hospital. (510a)

***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. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,**
**(a) infectious diseases; O. Reg. 79/10, s. 229 (3).**
**(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).**
**(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).**
**(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).**
**(e) outbreak management. O. Reg. 79/10, s. 229 (3).**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (5) The licensee shall ensure that on every shift,**
**(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**
**(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a staff member was designated to co-ordinate the program who had education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management. O. Reg. 79/10, s. 229 (3).

During an interview on April 5, 2017, the DON confirmed that they were the designated staff member co-ordinating the infection prevention and control program. The DON further confirmed that they were planning to designate registered staff #120 for this role. As qualification for the position of designated staff member coordinating the infection prevention and control program, it was confirmed by the DON that they had seven years of experience working in long term care and staff #120 had fourteen years of experience in long term care. The DON failed to provide documentation of education that either they, or staff #120 had undertaken, with regard to infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols or outbreak

management. (510a)
The licensee did not ensure the designated staff member co-ordinating the infection prevention and control program had education and experience in infection prevention and control practices. [s. 229. (3)]

2. The licensee has failed to ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4)

The home provided advanced foot care to residents. In providing this care, the foot care nurse used large nail clippers. These nail clippers were shared among residents. The home's policy, index number RCS K-20, titled "Foot Care Support", last revised July 15, 2013, under the heading 'Infection Control', directed that cleaning techniques focus on general preventative measures based on evidence based practice guidelines to ensure care of equipment and that the tool cleaning procedure included the two processes used in nursing foot care practices, those being cleaning and disinfecting equipment. While this policy directed the reader to the Infection Prevention and Control (IP&C) manual, regarding sterilization, review of the IP&C manual with the DON, confirmed the absence of any direction regarding sterilization. The DON did provide a policy from the Resident Care and Service Manual, index number RCS E-80, titled "Cleaning of Medical/Personal Care Equipment and Contact Surfaces", which provided direction for the care of multiple use nail clippers/scissors. These nail clippers/scissors were to be wiped clean and soaked in Virox for 20 minutes, then removed and allowed to air dry. The DON confirmed that this is the process used at the home.
Review of the Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings, 3rd edition, from the Provincial Infectious Diseases Advisory Committee (PIDAC), last revised in May 2013 and found on the Public Health Ontario, Partners for Life website, directed that foot care equipment was designated critical equipment and required cleaning followed by sterilization, using steam autoclave or dry heat.
Staff did not participate in implementing the Infection Prevention and Control program when they did not ensure evidence based practice guidelines as set out by PIDAC, were included in the home's policy, index I.D.#RCS E-80, that described cleaning processes for multiple use nail clippers. (510a) [s. 229. (4)]

3. The licensee failed to ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (b) the symptoms are recorded and that immediate action is

taken as required.

In March 2017, the Minimum Data Set (MDS) Assessment for resident #004 identified that the resident had an infection. The documentation by registered staff in the progress notes confirmed that the resident was displaying symptoms of infection in February 2017, which worsened four days later requiring treatment. Review of the plan of care did not include consistent ongoing monitoring and recording of symptoms every shift. Interview with the DON confirmed that the registered staff were to monitor and record symptoms of infection every shift when the resident began receiving treatment. Interview with the Interim Administrator confirmed that the staff did not monitor and record symptoms every shift, as required. (528)

***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 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 :**

The licensee failed to ensure any plan, policy, protocol, procedure, strategy or system was complied with.

A. In accordance with Ontario Regulation (O. Reg) 79/10, r. 68. (2)(d) requires every licensee of a long-term care home to ensure that as part of the organized programs of nutrition care and dietary services, the programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and

hydration.

The home's policy, "Resident Hydration, Index I.D: TCS C-40", revised September 4, 2013, stated night registered staff will total the amount of fluid consumed by the resident on a 24-hour basis for comparison to the amount specified in the plan of care. Registered staff will initiate a Dietary Referral form for each resident who has not consumed their required amount of fluids for the 24-hour period over a three day time span once it is determined there is no particular reason for reduced consumption. An electronic progress note will be included in the residents chart identifying this action.

i) Resident #017's plan of care identified they were at nutritional risk and had a minimum beverage target. Review of their fluid intake record from January to March 2017, revealed they did not meet their beverage target over 90 percent of the time. Their clinical record revealed only one dietary referral was made when they did not meet their beverage target minimum for three days; however, no other referrals were made during the review period when they did not meet their target for three consecutive days.

Interview with PSW #102 reported they promoted intake and they were unaware whether the resident was meeting their hydration requirements. Interview with the Registered Dietitian (RD) who reported recent coaching and education was provided to registered staff to complete dietary referrals when residents did not meet their hydration requirements for three days as historically registered staff were not sending dietary referrals as directed in the home's hydration policy. The RD confirmed they had not received referrals to assess resident #017 on all occasions during the review period when the resident did not meet their fluid requirement. (585)

ii) Resident #015's plan of care identified they were at nutrition risk, and had a minimum beverage target. Review of their fluid intake record in March 2017, revealed they had not met their beverage target minimum for three consecutive days. Their clinical record did not indicate documentation or assessment of the resident's intake in an electronic progress note or Dietary Referral form when they had not meet their fluid requirement for three consecutive days. Interview with the Registered Dietitian (RD) confirmed a Dietary Referral was not made when resident #015 did not meet their fluid requirement for three days. (585)

B. The home's Medication Management MediSystem policy "Transfer/Discharge/Deceased Procedure", revised January 2017, identified that the home is responsible for notifying the pharmacy within 24 hours of an admission, medical

absence, psychiatric absence, discharge or death of a resident as set out in Ontario Regulation 79/10 s. 121. Methods by which the home can notify the pharmacy included faxed "Resident Status Medication Update form", to write the status on a physican order form, or to phone MediSystem Pharmacy staff and verbally indicate the change in status.

i. The plan of care for resident #090 identified that the resident was transferred to hospital in 2017. The family of the resident identified that approximately two months later, they continued to receive billing for medication from MediSystem Pharmacy. Review of the plan of care did not include any documentation to support that the home had notified the pharmacy when the resident left the home. Interview with MediSystem Pharmacy identified that they were not notified of the resident's absence until approximately three and a half weeks after the resident had left the home.
ii. The plan of care for resident #070 identified that the resident was transferred to the hospital in 2017. The family of the resident identified that two months later, they continued to receive billing for medication from MediSystem Pharmacy. Review of the plan of care did not include any documentation to support that the home had notified the pharmacy when the resident left the home in February 2017. Interview with MediSystem Pharmacy identified that they were notified of the resident's absence approximately three weeks after the resident left the home. (528)

C. Ontario Regulation 79/10, s. 231(b) directs that every licensee of a long term care home shall ensure that the resident's written record is kept up to date at all times.

The home's policy index I.D. # C-45, titled Pronouncement of Expected Death, with an original date of September 18, 2013, and no revised date, directed that registered staff would use the Pronouncement of Expected Death checklist to complete identified steps, including a signature from the funeral home on the pronouncement form indicating date and time of removal of the deceased and that staff would make a copy of the signed form, giving the funeral home staff the original and file the copy in the resident's chart. Resident #050 died in 2016. Review of the clinical record revealed the absence of a Pronouncement of Expected Death form. When asked about this, the DOC produced the form, stating that it had been filed in a binder where documentation of resident's deaths are kept. Review of the document revealed the absence of a signature from the funeral home indicating the date and time of the removal of the deceased from the home. The above was confirmed by the DOC.
The home's policy was not complied with when a completed copy of the Pronouncement of Expected Death record was not kept with the resident's record. (510a)

***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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.***

---

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must have been kept closed and locked.

On March 24, 2017, at 1055 hours during an initial tour of the home, an exit door across from the Activity/Dining Room that lead to a non-resident outdoor area was found unlocked. Long Term Care (LTC) Homes Inspector#585 was able to open the door without entering a code into the access control system connected to the door. Housekeeping staff #106 and PSW #108 reported they were unaware of any issues with the door not locking properly. Later in the morning, maintenance staff was observed assessing the door. Housekeeping staff #106 confirmed the door was not closing properly. Although there were not residents in the immediate area surrounding the door, residents were observed in the hallway leading to the door and often sat in front of the door between meals. Following the second observation, the door was found locked; however, the home failed to ensure that all doors leading to outside of the home were kept closed and locked.

***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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, 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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The home's policy "Foot Care Support: RCS K-20", dated July 2013 stated that preventative and basic foot care will be provided to residents in accordance with their individualized needs. Responsibilities of registered staff included but were not limited to, assessing all residents feet on admission and quarterly and it will include at a minimum; degree of symmetry, presence of significant structural deviations, condition of the skin, condition of the nails, circulation, sensation, changes related to aging, presence of corns calluses warts ulcers and infections. The assessment will be completed in Point Click Care (PCC) including a summary of visit and interventions documented in the care plan. The frequency of foot care will be provided based on individualized resident needs.

In May 2016, the plan of care for resident #090 identified that the resident had specialized foot care every six weeks from the foot care nurse who worked within the home. The resident waited longer than six weeks for foot care on one occasion in 2016 and then the frequency was changed. However, review of the clinical health record identified the resident continued to receive foot care every six weeks. Interview with RPN #105 confirmed they were the foot care nurse in 2016, and foot care was not provided at the frequency in the plan of care as it was "not required" but there was no assessment to document the resident's foot conditions or rationale for timing of the resident's treatment plan. Interview with the DON revealed that all residents in the home were provided specialized foot care at no additional cost, every six weeks, by a foot care nurse supplied by the home, and that PSW staff are to verbally notify the registered staff when foot care was required. Furthermore, the plan of care did not include a detailed foot care assessment, as required in the homes policy; but did include an intervention of foot care every six weeks. Interview with RPN #105 confirmed that they were responsible for specialized foot care in 2016 and comprehensive foot assessments were not completed for the residents as required in the policy, identifying that they would document any abnormal findings.

B. The plan of care for resident #037 that the resident was to receive specialized foot care every six weeks. Review of 2016 and 2017 dates of when the resident received foot care identified that the resident did not receive foot care consistently every six weeks as outlined in their plan of care. The resident had to wait greater than six weeks on three occasions. Interview with RPN #105 confirmed that they were responsible for specialized

foot care in 2016 and confirmed foot care was received on reviewed dates. Foot care services of cutting the toe nails was not completed according to the resident's plan of care. Furthermore, the plan of care did not include a detailed foot care assessment, as required in the homes policy. Interview with RPN #105 and DON confirmed that comprehensive foot assessment was not completed for resident #090, as required in the home's policy. (528)

***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 the resident receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, 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).**

**Findings/Faits saillants :**

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, if clinically indicated.

A. The plan of care for resident #037 identified that the resident had areas of altered skin integrity, In March 2017, the Nurse Practitioner (NP) assessed an area and outlined daily treatment that was required. Weekly wound assessments were not completed consistently for two weeks, at which time, the wound was documented as worsened. Interview with RN # 110 confirmed that registered staff did not complete a weekly wound assessment of resident's area of altered skin integrity.

B. The plan of care for resident #004 identified that the resident had an area of altered skin integrity. Review of registered staff documented assessments did not include weekly wound assessments, as follows:
i. From October 2016 to February 2017, five weekly wound assessments were not completed
Interview with RN #100 confirmed that although treatment continued and was documented as being completed, weekly wound assessments were not completed on five occasions for resident #004's area of altered skin integrity, as required. (528)

***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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, 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 :**

The licensee failed to ensure that the resident who was incontinent had 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 was implemented

In 2016, registered staff documented that resident #090 was displaying responsive behaviours which made their toileting plan ineffective. Review of the written plan of care identified that the resident was frequently incontinent of urine and was on a scheduled toileting plan; however, did not include any specific interventions for staff on how they were to manage the resident's behaviours when toileting. Interview with RN#121 confirmed the they were often unable to toilet the resident. Interview with the DON confirmed that although the staff was unable to toilet the resident due to their behaviours, the interdisciplinary team did not create a plan to manage the resident's bladder incontinence, as evidenced by, documented episodes of the resident being incontinent. (528)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are incontinent have 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. 72. Food production**

**Specifically failed to comply with the following:**

**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 failed to ensure that the home had and that the staff of the home complied with a cleaning schedule for the food production, servery and dishwashing areas.

A. On March 24, 2017, in an initial tour of the home, the patio dining room servery was found unclean as the cupboard below the sink had notable dry solid and fluid debris on the base and sides of the inner aspect of the cabinet door and walls. On April 5, 2017, prior to lunch meal service, the patio dining room servery remained in an unclean condition and significant dry debris was found in the hand wash sink.

B. On April 5, 2017, the activity room dining servery was also found unclean. Prior to lunch meal service, dry food debris was observed in a cutlery drawer, as well as dry fluid debris in cutlery tray that contained cutlery for resident use. The cupboard above the counter contained a notable build-up of dry food debris. The cupboard below the sink had notable dried fluid debris and dried food debris on the inner aspect of the cupboard door. Cupboard doors were covered with dry fluid debris and cupboard handles were oily to touch. The hand wash sink contained brown fluid debris in the sink and around the drain.

Interview with the FSM confirmed the home's food production system did include a cleaning schedule for the cleaning of cupboards, sinks and drawers and the servery area was not in a clean condition. During an interview with the ESM who reported environmental staff were responsible to clean the cupboards below the hand wash sink in servery areas; however, they the confirmed the home's housekeeping routines and job description did not specify that environmental staff were to keep area below the hand wash sinks clean. (585) [s. 72. (7) (c)]

***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 the home has and that the staff of the home complies with a cleaning schedule for the food production, servery and dishwashing areas, to be implemented voluntarily.***

---

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On March 31, 2017, two cards of medications were observed in the unlocked desk drawer of the DOC. The DOC confirmed that the drugs were controlled substances. At the time of interview, the DOC reported that disposed narcotics were to be stored in a lock box in a stationary locked cabinet in their office. The home's Medisystem Pharmacy policy titled "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances", last reviewed January 17, 2017, directed that, "discontinued narcotics and controlled substances are to be removed from the medication cart and the individual Narcotic and Controlled Substance Administration Record signed and dated prior to being placed into the double locked centralized storage area within the home". The DOC confirmed the controlled substances were not stored in the separate double locked stationary cupboard, in the home. [s. 129. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.***

---

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. Has the licensee ensured that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

During initial tour of the home on March 24 2017, a raised toilet seat was observed to be sitting on resident #025's toilet. The bathroom was a shared bathroom for multiple residents. When weight was placed on the left handle bar the raised toilet seat slid back and appeared loose. The same observation was made on March 28, 2017, the following week. Interview with PSW #104 confirmed that the seat was loose and after two attempts, the seat could not be tightened. The home's preventative maintenance procedure identified that all resident rooms including but not limited to, toilets ad grab bars, were to be inspected on the fifth day of every month. Furthermore, PSW or housekeepers were to monitor resident's space for safety concerns daily and could report disrepair at any time. Although, the home followed their preventative maintenance schedule, they were unaware of the raised toilet seat in disrepair, which was observed over four days (before and after a weekend). (528) [s. 90. (2) (b)]

---

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Review of the medication processes in the home was undertaken with the DON on March 29, 2017. There were some government stock drugs stored in a cupboard in the medication room in the home area and additional government stock drugs stored in a locked storage room on the lower level. On two occasions, the DON confirmed they kept a five month supply of government stock drugs at the home.
The home did not ensure that when drugs are obtained for use in the home, no more than a three month supply is kept in the home at any time. [s. 124.]

---

**Issued on this 8th day of May, 2017**

**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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | CYNTHIA DITOMASSO (528), IRENE SCHMIDT (510a), LEAH CURLE (585) |
| **Inspection No. / No de l'inspection :** | 2017_570528_0012 |
| **Log No. / Registre no:** | 006384-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 2, 2017 |
| **Licensee / Titulaire de permis :** | RYKKA CARE CENTRES LP<br>3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2 |
| **LTC Home / Foyer de SLD :** | ORCHARD TERRACE CARE CENTRE<br>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)

**Linked to Existing Order / Lien vers ordre existant:** 2016_205129_0011, CO #002;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure the following:
i. that all responsive behaviour assessments required under the home's Responsive Behavior Philosophy and Assessment Policy, are completed when all residents, including resident #015, have a change in their behaviours
ii. that the interdisciplinary team will identify and review responsive behaviours for all residents, and develop strategies to manage those behaviours, including but not limited to referrals to external resources; and ensure the resident's responses to the implemented strategies are documented
iii. that all staff are aware of their responsibilities related to responsive behaviours management according to the home's "Responsive Behavior Philosophy"

The plan is to be submitted to cynthia.ditomasso@ontario.ca no later than June 7, 2017.

**Grounds / Motifs :**

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of potential for actual harm/risk, scope of pattern with two out of three residents, and ongoing non-

compliance with a Compliance Order (CO) issued in November 2016, and Voluntary Plan of Correction (VPC) issued in September 2016.

A. Resident #015 was admitted to the home in late 2016, at which time a responsive behavior assessment was completed and revealed that the resident had responsive behaviours with triggers identified. The assessment noted the resident to be at risk and that the care plan had been updated.
i. Review of the MDS assessment completed December 2016, identified a change in mood and behaviours. Further review of the clinical record revealed that the resident continued to demonstrated responsive behaviours in 2017.
Ii. In spite of this identified change in mood and behaviors, a responsive behaviors assessment was not completed for resident #015 in December 2016, and new interventions were not identified. Review of the clinical record for resident #015 revealed that in February 2017, the resident demonstrated ongoing behaviours. However, a responsive behaviors assessment was not completed until the following month. Review of this assessment revealed that the behaviors identified in the clinical record in February 2017, were not reflected in the assessment and in fact, it contained the same information as the December 2016, responsive behavior assessment.
iii. The Home's policy titled Responsive Behavior Philosophy, under 'Behavioral Management and Responsive Behavior Philosophy and Assessment', the number two under procedure, directed that the responsive behavior assessment occurs quarterly and if the resident has a significant change; and under 'Outcome', stated that all residents with responsive behaviors would be assessed, interventions put in place and referrals to external resources accessed.
iv. Review of the clinical record revealed that, in spite of the documented ongoing change in behaviors between 2016 and 2017, there were no additional interventions identified or implemented for the management of behaviors for resident #015 until March 2017, as confirmed by the DOC and the Quality/Business Manager.
v. The DOC and QI/Business Manager confirmed resident #015 did not receive a quarterly responsive behavior assessment in December 2016, in spite of a change in behaviors identified in MDS, nor did they receive a responsive behavior assessment in February 2017, when behaviors continued to be demonstrated. The DOC also confirmed the document the home referred to as the care plan was not updated with additional interventions until March 2017, subsequent to this inspection being conducted.

The licensee did not ensure strategies were developed and implemented when resident #015 demonstrated a decline in behaviors over a five month period. Actions were not taken by the home to respond to the needs of resident #015, including assessments, reassessments and interventions, when the resident continued to demonstrate a change in behaviors, resulting in a potential for actual harm to resident #015 and co-residents.

B. In December 2016, dementia observational system (DOS) charting was initiated for an identified resident and identified event; however, review of their clinical record between December 2016 to February 2017, revealed DOS charting was not completed every 30 minutes on 44 out of 61 days. Interview with PSW # 119 who reported the resident's planned care was for staff to monitor and document their behaviours every 30 minutes. The Administrator reported in an interview that the resident had responsive behaviours and staff were to complete the DOS charting; however, confirmed the resident's responses to the intervention to receive DOS charting was not implemented. (510a)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 02, 2017

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

**Order / Ordre :**

The licensee shall ensure the following:

i. that all residents receiving high alert medication insulin, including residents #090, #037 and #015, are monitored according to the home's "Algorithm for Management of Hypoglycemia" and the resident's responses are documented
ii. that all staff follow the protocol in relation to a resident who has a blood glucose of less than 4.0 mmol/L
iii. provide education to all registered staff related to 'high alert medications' and their responsibilities for monitoring and documentation related to those medications

**Grounds / Motifs :**

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of potential for actual harm/risk, scope of widespread with three out of three residents, and ongoing non-compliance with a written notification unrelated.

The home's "Algorithm for Management of Hypoglycemia" undated, identified that if a resident had a blood glucose of less than 4.0 millimoles per litre

(mmol/L) or was showing signs and symptoms of hypoglycemia and was conscious, to complete the following:
i. give 15 grams of carbohydrate
ii. retest blood glucose in 15 minutes
iii. if next meal is more than one hours away give protein plus carbohydrate snack
iv. if next meal is less than an hour away set up meal as soon as possible

A. The plan of care for resident #090 identified that the resident was on a combination of medications and staff were checking capillary blood glucose (CBG).
i. On an identified day in July 2016, the CBG was documented below 4.0 mmol/L. Registered staff documented they provided the resident with interventions; but there was no documentation that the CBG was rechecked after the intervention was provided.
ii. On an identified day in November 2016, the CBG was documented less than 4.0 mmol/L. Registered staff documented that medication was held; however, did not indicate if 15 grams of carbohydrate was given or the CBG was rechecked in 15 minutes.
iii. On an identified day in December 2016, the CBG was documented as less than 4.0 mmol/L. Registered staff documented that an intervention was implemented, but there was no recheck of the CBG completed.

B. The plan of care for resident #034 identified that the resident was on a combination of medication and staff were checking the resident's CBG.
i. On an identified day in December 2016, the CBG was documented as less than 4.0 mmol/L. No further action was noted.
ii. On an identified day in January 2016, the CBG was documented was less than 4.0 mmol/L. Documentation noted the registered staff rechecked the CBG an hour later, at which time, it was greater than 4.0 mmol/L.
iii. On an identified day in January 2017, the CBG was less than 4.0 mmol/L. Staff did not document interventions or recheck until over an hour later, and the CBG was greater than 4.0 mmol/L.
iv. On an identified day in February 2017, the CBG was 4.0 mmol/L. Staff did not document interventions or a recheck until over an hour later, which stated the CBG was greater than 4.0 mmol/L.

C. The plan of care for resident #016 identified that the resident was taking a combination of medications, as well as a corticosteroid, and staff were

monitoring the resident's CBG.
i. On an identified day in January 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented interventions were given but there was no recheck of the resident's CBG completed.
ii. On an identified day in March 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented that the interventions were implemented, but did not specify whether the resident received a carbohydrate or whether the CBG was rechecked.
iii. On an identified day in March 2017, the CBG was documented less than 4.0 mmol/L. Registered staff documented that interventions were implemented; however, no CBG recheck was completed.

Interview with the DON confirmed that staff were required to recheck the CBG after 15 minutes of providing a carbohydrate, as outlined in the protocol; however, in the above examples, the registered staff did not follow the home's hypoglycemia protocol in relation to documenting what intervention was provided to a resident with a CBG of less than 4.0 mmol/L and rechecking the resident's blood sugar within 15 minutes for residents # 090 #037 and #016 . (528) (528)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 02, 2017

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure the following:

i. that all residents are provided the care specified in their plan in relation to falls prevention, and safety when using transportation services
ii. educate all PSW and nursing staff in relation to their responsibilities of providing the care as specified in the plan of care with relation to falls prevention and safety when using transportation service.

**Grounds / Motifs :**

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of actual harm/risk, scope of isolated with one out of three residents, and ongoing non-compliance with a Voluntary Plan of Correction (VPC) issued in August 2015, and May and August 2016.

A. In December 2016, resident #090 had a fall resulting in an injury. Review of the plan of care identified that the resident was at risk for falls and was not to be left unattended when toileted. Interview with PSW #119 identified that the resident was left unattended when the staff left the room to assist the second resident. When they returned the resident had fallen. Interview with the DON confirmed that the two PSW staff did not attend to the resident at all times when toileted, which was required in the written plan of care. (528)

B. A medical directive for resident #090 stated that a medication could be given every four to six hours as needed for a symptom and to call the physician if no improvement within 24 hours.
In January 2017, resident #090 had a a symptom that required a medication to

be given per the medical directive. The physician assessed the resident the following day and noted the symptom from the day prior and no new orders were received. Review of the progress notes identified that the resident had ongoing symptoms and medication was administered with good effect up to four days after the physician assessed the resident. Interview with regular staff RN #110 and #120 and the Interim Administrator confirmed that after the physician assessed the resident, they continued to have the ongoing symptom; however, the physician was not notified, as required in the medical directive. (528)

C. The plan of care for resident #090 identified that the resident had multiple co-morbidities and was eligible to use outside services if they were with a support person.

On an identified day in August 2016, the resident left the home without a support person. Interview with staff #122 and medical professionals from the destination confirmed that the resident reached the destination safely and returned less than two hours later with no harm to their health or well being. Staff #122 confirmed that the resident should not have left the home without a support person. Interview with the DON and Interim Administrator confirmed that the resident was provided with a support person when they left the home in August 2016. (528) (528)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 02, 2017

**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that all registered staff:
i. follow the College of Nurses of Ontario (CNO) Standards for medication practices when administering medications to residents,
ii. are re-trained on MediSystems policies related to medication transcription and administration.

**Grounds / Motifs :**

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of actual harm/risk, scope of isolated with two residents, and ongoing non-compliance with Voluntary Plan of Correction (VPC) in a similar area in November 2016.

A. The plan of care for resident #090 identified that on an identified day in June 2016, the resident received the wrong dosage of medication at the wrong time. As a result of the medication incident, the resident required increased monitoring but no harm occurred. Interview with the DOC confirmed that in June 2016, resident #090 received the incorrect dose of medication. (528)

B. In February, 2017, a change in medications were ordered by the physician. Registered staff #116 discontinued the incorrect medication for resident #039, which was rechecked by registered staff #110. Review of the clinical health record revealed that the resident did not receive the medication for four days and as a result had symptoms that required treatment at the hospital. Interview with the DOC confirmed that the medication was discontinued in error and was not administered to resident #039 in accordance with the directions for use specified by the prescriber, resulting in their transfer to hospital. (510a) (528)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 02, 2017

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 :** 005

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

**Order / Ordre :**

The licensee shall ensure that they develop and implement a procedure based on prevailing practices within relation to cleaning, disinfecting and sterilization of foot care equipment.

**Grounds / Motifs :**

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of potential for actual harm/risk, scope of widespread with all of the residents being effected, and ongoing non-compliance with Voluntary Plan of Correction (VPC) in a similar area in May 2016.

The home provided advanced foot care to residents. In providing this care, the foot care nurse used large nail clippers. These nail clippers were shared among residents. The home's policy, index number RCS K-20, titled "Foot Care Support", last revised July 15, 2013, under the heading 'Infection Control', directed that cleaning techniques focus on general preventative measures based on evidence based practice guidelines to ensure care of equipment and that the tool cleaning procedure included the two processes used in nursing foot care practices, those being cleaning and disinfecting equipment. While this policy directed the reader to the Infection Prevention and Control (IP&C) manual, regarding sterilization, review of the IP&C manual with the DON, confirmed the absence of any direction regarding sterilization. The DON did provide a policy from the Resident Care and Service Manual, index number RCS E-80, titled "Cleaning of Medical/Personal Care Equipment and Contact Surfaces", which provided direction for the care of multiple use nail clippers/scissors. These nail clippers/scissors were to be wiped clean and soaked in Virox for 20 minutes, then removed and allowed to air dry. The DON confirmed that this is the process used at the home.
Review of the Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings, 3rd edition, from the Provincial Infectious Diseases Advisory Committee (PIDAC), last revised in May 2013 and found on the Public Health Ontario, Partners for Life website, directed that foot care equipment was designated critical equipment and required cleaning followed by sterilization, using steam autoclave or dry heat.
Staff did not participate in implementing the Infection Prevention and Control program when they did not ensure evidence based practice guidelines as set out by PIDAC, were included in the home's policy, index I.D.#RCS E-80, that described cleaning processes for multiple use nail clippers. (510a) (510a)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 02, 2017

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

## 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 2nd day of May, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Cynthia DiTomasso

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