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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2014	2014_188168_0007	H-000193-14H-000194-14	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

Long-Term Care Home/Foyer de soins de longue durée

DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

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

LISA VINK (168), ASHA SEHGAL (159), CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 27, 2014, and March 4, 5, 6, 7, 10, and 17, 2014.

This Complaint Inspection Report includes inspections for log numbers: H-000744-13, H-000526-13, H-000770-13, H-000193-14 and H-000194-14.

This Inspection Report includes a finding of non-compliance related to LTCHA, 2007, section 6, identified during Critical Incident Inspection log numbers H-000534-13/H-000536-13, which was completed concurrently with this inspection.

This Inspection Report includes findings of non-compliance related to O. Reg 79/10 section 8, identified during the Follow Up Inspection log number H-000863-13 which was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Registered Dietitian (RD), Food Service Manager (FSM), Physiotherapist, Physiotherapist Assistant, registered nursing staff, personal support workers (PSW), unregulated staff and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation including but not limited to: clinical health records, policies and procedures, and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Food Quality
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The RD did not complete a nutritional assessment for all residents whenever there was a significant change in condition or assess nutritional status, including height,

weight and any risks related to nutritional care or hydration status and any risks related to hydration.

A. The RD did not assess resident #021 for hydration status and risks related to hydration when the resident's fluid intake was less than their assessed fluid requirement of 1590 ml a day or their target requirement of 1250 ml a day.
i. The food and fluid intake record for the resident identified they did not meet their assessed fluid requirement of 1590 ml a day, as identified on the plan of care, on any day recorded over the three month period of October to December 2013.
ii. On October 31, 2013, the revised plan of care indicated the total fluid requirement of 1590 ml a day was calculated based on 79 percent of the total fluid requirement at 30 ml/kilogram (kg). A review of the health record confirmed the recorded weight on October 7, 2013. However, a reassessment of the resident's hydration requirement did not occur based on the October 2013, recorded weight. The resident did not meet the target of 1250 ml/day fluid requirement. Fluid intake records for October, 2013, indicated that 20 out of 30 days the resident did not meet the target, for November 2013, fluid intake was 19 out of 30 days below the target requirement, and for December 2013, fluid intake was 25 out of 31 days below the required intake. Progress notes dated October 30, 2013, identified a dietary referral was made related to low fluid intake for the last three days. On November 4, 2013, documentation by the FSM indicated that a referral was made to the RD regarding the low fluid intake. The Dietary Referral Response completed by the RD on November 13, 2103, indicated to "continue with the current nutrition care plan, the resident's intake meets assessed needs". The progress notes dated November 14, 2013, identified the Dietary Referral Response by the RD was related to wound and skin. However, an assessment of the poor hydration did not occur at the time of the review and action was not taken to address the poor hydration or the risks related to nutrition, as the plan was to continue with the current nutritional interventions. On November 29, 2013, another dietary referral was initiated which stated "resident unable to meet required fluid intake for 3 days". There was no supportive documentation that the Dietary Referral Response by the RD occurred. Review of health record and staff interviewed confirmed the assessment of the poor hydration and the risks related to nutrition did not occur.
iii. The RD did not assess resident #021 when there was a significant change in intake. The food and fluid intake records for the resident were reviewed for October, November and December 2013. The intake records indicated that the resident was eating poorly, routinely refusing the dinner meal, and afternoon/evening nourishment. The FSM progress notes dated November 4, 2013, identified a change in the

resident's health status. The nutrition note noted the food intake varied 25-50 percent with refusal. The nutrition status remained assessed at moderate nutritional risk due to required assistance with eating. The plan was to continue to provide the prescribed diet, despite documented ongoing poor oral intake and hydration. An evaluation of poor intake did not occur and the RD did not reassess the interventions nor were different approaches taken in the revision of the plan to address the concerns identified related to poor intake. [s. 26. (4) (a),s. 26. (4) (b)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

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 did not ensure that each menu provided for a variety of foods, including fresh seasonal foods each day, from all food groups in keeping with Canada's Food Guide as it exists from time to time.

A review of the home's four week menu cycle offered to residents lacked a variety of seasonal fresh fruits and vegetables. The planned Fall and Winter menu cycle indicated the number of times fresh fruit was served was three meals a week (3 times in 21 meals a week) and the fresh fruits and vegetables served did not reflect seasonal foods available. It was confirmed by the FSM that most of the fruit based desserts served were a canned fruit component. Residents interviewed reported concerns regarding the quality of food and the availability and servings of fresh fruits and vegetables. [s. 71. (2) (b)]

2. Not all resident were offered the planned menu items at each meal.

At the lunch meal on February 27, 2014, two identified residents who were assisted with eating were not served/fed soup as per the planned menu. Staff interviewed reported that the residents did not like soup, however, a dislike was not identified on the kitchen diet list or the plans of care. The two residents were offered and consumed soup after the Inspector intervened. Interview with the RD confirmed she was not aware that the staff had made food choices for the residents. [s. 71. (4)]

Additional Required Actions:

CO # - 002 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 each menu provides for a variety of foods, including fresh seasonal foods each day from all food groups in keeping with Canada's Food Guide as it exists from time to time, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

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).

Findings/Faits saillants :

1. The licensee did not ensure that the food production system included standardized recipes and production sheets for all menu items.

A. The production sheets for "Week 1 - Thursday" available for staff preparing the planned lunch menu did not include the food items needed to be prepared.
i. On February 27, 2014, the planned lunch menu consisted of cream of mushroom soup, grilled cheese sandwiches, peas and carrots and Rice Krispie squares. The menu items listed on the production sheet were for whole wheat vegetable lasagna and garden salad. The FSM confirmed that the menu items listed on the production sheets were incorrect and did not correspond to the food items posted on the planned lunch menu. [s. 72. (2) (c)]

2. Not all foods were prepared, stored and served using methods which preserved taste, nutritive value, appearance and food quality.

During the observed food production in the kitchen on February 27, 2014, staff preparing menu items did not follow the recipes. Recipes of cream of mushroom soup, turkey sandwich and grilled cheese sandwich were not followed. Staff preparing menu items did not measure or weigh the ingredients specified in the recipes.
i. The grilled cheese recipe had indicated to assemble the sandwich using 60 grams of cheddar cheese with two slices of bread. Staff had used half of the identified portion (30-40 grams) of sliced processed cheese in preparation.
ii. The sliced turkey sandwich recipe directed staff to use 80 grams of meat for the sandwich filling. The cook interviewed confirmed that the sliced turkey was not weighed and that one slice of meat, approximately 30 grams, was used in the preparation of the sandwich. The protein content of the sandwiches served at lunch was not adequate in quantity and nutritional value.
The FSM confirmed that the cheese and meat sandwich filling was less than the quantities listed in the recipe.
iii. The consistency of the cream of mushroom soup served at lunch was thin and watery. [s. 72. (3) (a)]

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 the food production system includes standardized recipes and production sheets for all menu items, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

A. The plan of care for resident #021 was not revised with changes in care needs. The resident was noted to have areas of altered skin integrity. Progress notes and staff interview identified that the resident was known to remove the dressings applied to protect and treat the skin. Progress notes identified that staff initiated a specified dressings in an effort to prevent additional trauma to the skin. The plan of care identified the altered skin integrity, however was not revised with the change in care needs related to the identified behaviour of the resident.
B. The clinical record for resident #021 identified family reports to staff that the resident experienced unusual symptoms on a specified date in 2014. Staff responded to these concerns with nursing measures to promote comfort. Interview with DOC's identified that a discussion was held with the family that same day, regarding the symptoms, and a decision was made that the resident would be assessed by the physician, the following day. The resident was not assessed as planned by the physician. Three days after the original concern was identified/discussed the physician was contacted and orders were received to treat a possible infection. Later that same day the resident experienced additional symptoms that required transport to hospital. The resident's plan of care was not revised with the changes in care needs and the physician was not contacted for three days, to treat the identified symptoms.
C. The plan of care for resident #003 was not reviewed and revised with changes in care needs. The resident previously utilized the services of the Behavioural Supports Ontario (BSO) and was discharged from the program. In January 2014, the resident was referred to the program due to an identified need. The current plan of care identified the resident had been referred to the BSO and Outreach Team in May 2013, and that they were discharged in July 2013 from the BSO. The plan was not updated when records indicated an increase in responsive behaviour and a referral back to the BSO and to the Outreach Team in January 2014. The DOC confirmed that the plan had not been updated with this change in need. [s. 6. (10) (b)]

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. 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 :

1. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive a skin assessment by a member of the registered nursing staff, with a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. Resident #021 had a number of areas of altered skin integrity. The identified areas were not assessed using a clinically appropriate assessment tool, designed for skin and wounds.
i. A skin tear was first identified on August 9, 2013, and resolved on August 30, 2013, was not assessed using a clinically appropriate tool.
ii. A small cut which was identified in the progress notes on September 17, 2013, and required a dressing to stop the bleeding, was not assessed using a clinically appropriate tool in Point Click Care (PCC) or Pixalere.
iii. An ulcer was first identified on December 24, 2013, was not assessed using a clinically appropriate assessment tool until December 31, 2013.
Interview with the nursing staff confirmed that all assessments related to areas of altered skin integrity would be located in Pixalere or PCC. It was confirmed that the identified areas of altered skin integrity were not assessed using a clinically appropriate tool, designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a Registered Dietitian who was a member of the staff of the home.

A. Resident #021 was noted to have altered skin integrity specifically: a skin tear was identified on August 8, 2013, which was resolved on August 30, 2013, and a second tear was identified on September 8, 2013, which was being treated into November, 2013. The RD did not assess the resident specifically related to the areas of altered skin integrity until November 14, 2013, at which time interventions were initiated to assist in wound healing, which was confirmed during an interview with RD and nursing staff.
B. Resident #205 had areas of altered skin integrity, specifically: a skin tear identified on January 24, 2014, a second skin tear identified on February 10, 2014, and a open area identified in February, 2014. Interview with the RD confirmed that she had not received a referral regarding these ongoing areas of altered skin integrity and for this reason the resident was not assessed for this identified need. [s. 50. (2) (b) (iii)]

3. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Resident #021 had altered skin integrity which was not assessed weekly by the registered nursing staff.
i. The resident had a skin tear on August 9, 2013. This area was treated with a dressing and required the use of a topical cream before it was resolved on August 30, 2013. The area was included on the Treatment Administration Record and was consistently signed as being treated, however a documented reassessment during the period of time between August 9, 2013, and August 30, 2013, was not available.
ii. The resident sustained a skin tear on September 8, 2013. This area was not reassessed weekly from September 9, 2013, until October 7, 2013, and November 18, 2013, until December 9, 2013.
iii. The resident sustained a cut on September 17, 2013. This area was identified in the progress notes when initially identified and treated however there was no further mention of the area in the clinical record.
B. Resident #205 was identified to have altered skin integrity.
i. The resident had a skin tear on January 24, 2014. A review of the clinical records and interview with the nursing staff confirmed that the area was not reassessed weekly by the nursing staff.

ii. The resident had a skin tear on February 10, 2014. A review of the clinical records and interview with the nursing staff confirmed that this area was not reassessed at least weekly between February 17, 2014, and March 6, 2014.
iii. The resident was identified to have an area of altered skin integrity in February 2014. A review of the clinical records and interview with the nursing staff confirmed that this area was not reassessed at least weekly between February 17, 2014, and March 6, 2014. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 005 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 each resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, with a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

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 :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home had a "Continence Management Program, last revised May 2010" which

included a bowel protocol. This protocol identified that: "on the third (3) day without a BM, the registered staff to administer 30 ml of milk of magnesia as per order at hs, on the fourth (4) day without a BM administer a suppository (as ordered) by the day registered staff, on the fifth (5) day without a BM administer a fleet enema (as ordered) by the day registered staff".
1. Resident #021 experienced constipation according to the clinical record as identified below.
i. The resident had a bowel movement (BM) on August 29, 2013, however no interventions were recorded as completed until September 5, 2013, at which time a suppository was administered with results.
ii. The resident had a BM on September 28, 2013, and did not have another one until October 2, 2013.
iii. The resident had a BM on October 12, 2013, however no interventions were recorded as completed until October 16, 2013, when a suppository was administered with results.
iv. The resident had a BM on October 22, 2013, however no interventions were recorded as completed until October 27, 2013, when a suppository was administered with results.
v. The resident had a BM on October 27, 2013, and did not have another one until October 31, 2013.
vi. The resident had a BM on November 9, 2013, however no interventions were recorded as completed until November 14, 2013, when a suppository was administered with results.
vii. The resident had a BM on November 14, 2013, and did not have another one until November 18, 2013, following action of staff.
viii. The resident had a BM on November 24, 2014, however no interventions were recorded as completed until November 28, 2013, when a suppository was administered with results.
ix. The resident had a BM on December 2, 2013, however no interventions were recorded as completed until December 9, 2013, when a suppository was administered with results.
x. Interview with the DOC confirmed the expectation that staff follow the bowel protocol and if a resident did not have an order for the suggested intervention(s) that the physician be contacted for direction, and that this would be recorded in the clinical record.
2. Resident #205 had a BM on January 20, 2014, and not again until January 25, 2014, according to the flow sheets. Progress notes and Medication Administration Records (MAR) were reviewed for the period of time identified however there was no

documentation that the bowel protocol was followed according to the home's policy.
B. Staff in the home did not comply with the home's "Referral to the Registered Dietitian Policy, #FNSCN035, dated February 2, 2104". The policy indicated that "referrals to the RD will be made when there is a change in resident's status, when RAI outputs affecting eating have occurred require a review of the current nutrition interventions by the Registered Dietitian".
i. Staff interviews and documentation reviewed confirmed the policy was not followed for the nutritional care provided to resident #302 when their food and fluid intake record indicated they were eating poorly, not meeting the minimum target of fluid requirement and had a significant unplanned weight loss. A dietary referral was not initiated to reassess the resident as per home's policy.
C. Staff did not comply with the home's policy "Height and Weight Monitoring, FNSCN076" for residents #205 #300 and #302. The policy directed that residents with any change of weight of five percent or more from the previous month will be re-weighed within 24 hours and this value entered into Point Click Care (PCC).
The identified residents had significant weight changes and variances in monthly weights recorded. Re-weighs were not completed within 24 hours or entered into PCC as per the home's policy.
i. Resident #205 for: October, November, December, 2013 and January, February, and March, 2014.
ii. Resident #302 for: January, February, and March 2014.
iii. Resident #300 had a decline in weight by 7.6 percent over three months. Re-weighs were not taken or entered in PCC for January and February 2014. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee did not ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee did not ensure that the following was documented: the time of application, all assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning.

A review of resident #043's clinical record indicated that they were bedridden and required two bed rails in the upright position, at all times, while in bed, as a restraining device.
i. On March 6, 2014, a review of the January 2014, Restraint Record, indicated that there were 35 shifts during this month in which there was no documentation regarding the person who applied the device, the time of application, all assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning.
ii. On March 6, 2014, a review of the February 2014, Restraint Record, indicated that there were eight shifts during this month in which there was no documentation regarding the person who applied the device, the time of application, all assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning.
iii. On March 6, 2014, a review of the March 2014, Restraint Record, indicated that no record could be found in the daily flow sheet binder.
Interviews conducted with the registered staff confirmed that the Restraint Records for the months of January and February 2014, were incomplete and the Restraint Record for March 2014, had not been initiated. [s. 110. (7) 5.]

Issued on this 7th day of April, 2014

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), ASHA SEHGAL (159), CATHY FEDIASH (214)
Inspection No. / No de l'inspection :	2014_188168_0007
Log No. / Registre no:	H-000193-14H-000194-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 21, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	DUNDURN PLACE CARE CENTRE 39 MARY STREET, HAMILTON, ON, L8R-3L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBBIE BOAKES

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0006, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home shall ensure that a registered dietitian, who is a member of the staff of the home, will assess all residents for the matters referred to in paragraph 13 and 14 of subsection 3.

The plan should include a system for the implementation of strategies that addresses poor hydration and changes in resident's nutritional status.

The plan is to be submitted electronically by April 15, 2014, to Asha.Seghal@ontario.ca

Grounds / Motifs :

1. Previously issued August 2, 2013, as a Compliance Order

The RD did not complete a nutritional assessment for all residents whenever there was a significant change in condition or assess nutritional status, including height, weight and any risks related to nutritional care or hydration status and any risks related to hydration.

A. The RD did not assess resident #021 for hydration status and risks related to hydration when the resident's fluid intake was less than their assessed fluid requirement of 1590 ml a day or their target requirement of 1250 ml a day.

i. The food and fluid intake record for the resident identified they did not meet their assessed fluid requirement of 1590 ml a day, as identified on the plan of care, on any day recorded over the three month period of October to December 2013.
ii. On October 31, 2013, the revised plan of care indicated the total fluid requirement of 1590 ml a day was calculated based on 79 percent of the total fluid requirement at 30 ml/kilogram (kg). A review of the health record confirmed the recorded weight on October 7, 2013. However, a reassessment of the resident's hydration requirement did not occur based on the October 2013, recorded weight. The resident did not meet the target of 1250 ml/day fluid requirement. Fluid intake records for October, 2013, indicated that 20 out of 30 days the resident did not meet the target, for November 2013, fluid intake was 19 out of 30 days below the target requirement, and for December 2013, fluid intake was 25 out of 31 days below the required intake. Progress notes dated October 30, 2013, identified a dietary referral was made related to low fluid intake for the last three days. On November 4, 2013, documentation by the FSM indicated that a referral was made to the RD regarding the low fluid intake. The Dietary Referral Response completed by the RD on November 13, 2103, indicated to "continue with the current nutrition care plan, the resident's intake meets assessed needs". The progress notes dated November 14, 2013, identified the Dietary Referral Response by the RD was related to wound and skin.   However, an assessment of the poor hydration did not occur at the time of the review and action was not taken to address the poor hydration or the risks related to nutrition, as the plan was to continue with the current nutritional interventions. On November 29, 2013, another dietary referral was initiated which stated "resident unable to meet required fluid intake for 3 days". There was no supportive documentation that the Dietary Referral Response by the RD occurred. Review of health record and staff interviewed confirmed the assessment of the poor hydration and the risks related to nutrition did not occur.
iii. The RD did not assess resident #021 when there was a significant change in intake. The food and fluid intake records for the resident were reviewed for October, November and December 2013. The intake records indicated that the resident was eating poorly, routinely refusing the dinner meal, and afternoon/evening nourishment. The FSM progress notes dated November 4, 2013, identified a change in the resident's health status. The nutrition note noted the food intake varied 25-50 percent with refusal. The nutrition status remained assessed at moderate nutritional risk due to required assistance with eating. The plan was to continue to provide the prescribed diet, despite documented ongoing poor oral intake and hydration. An evaluation of poor

intake did not occur and the RD did not reassess the interventions nor were different approaches taken in the revision of the plan to address the concerns identified related to poor intake. [s. 26. (4) (a),s. 26. (4) (b)] (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that the planned menu items are offered and available at each meal and snack.

The plan is to be submitted electronically by April 15, 2014, to Asha.Seghal@ontario.ca

Grounds / Motifs :

1. Previously issued August 2, 2013, as VPC.

Not all resident were offered the planned menu items at each meal.

At the lunch meal on February 27, 2014, two identified residents who were assisted with eating were not served/fed soup as per the planned menu. Staff interviewed reported that the residents did not like soup, however, a dislike was not identified on the kitchen diet list or the plans of care. The two residents were offered and consumed soup after the Inspector intervened. Interview with the RD confirmed she was not aware that the staff had made food choices for the residents. (159)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

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. 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that all foods and fluids in the food production system are prepared using methods to preserve taste, nutritive value, appearance and food quality.

The plan is to be submitted electronically by April 15, 2014, to Asha.Seghal@ontario.ca

Grounds / Motifs :

1. Previously issued August 2, 2013, as a VPC.

Not all foods were prepared, stored and served using methods which preserved taste, nutritive value, appearance and food quality.

During the observed food production in the kitchen on February 27, 2014, staff preparing menu items did not follow the recipes. Recipes of cream of mushroom soup, turkey sandwich and grilled cheese sandwich were not followed. Staff preparing menu items did not measure or weigh the ingredients specified in the recipes.
i. The grilled cheese recipe had indicated to assemble the sandwich using 60 grams of cheddar cheese with two slices of bread. Staff had used half of the identified portion (30-40 grams) of sliced processed cheese in preparation.
ii. The sliced turkey sandwich recipe directed staff to use 80 grams of meat for the sandwich filling. The cook interviewed confirmed that the sliced turkey was not weighed and that one slice of meat, approximately 30 grams, was used in the preparation of the sandwich. The protein content of the sandwiches served at lunch was not adequate in quantity and nutritional value.
The FSM confirmed that the cheese and meat sandwich filling was less than the quantities listed in the recipe.
iii. The consistency of the cream of mushroom soup served at lunch was thin and watery. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0006, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that all residents are reassessed and their plans of care are reviewed and revised at least every six months and at any other time when their care needs change or the care set out int he plan is no longer necessary.

The plan is to be submitted electronically to Lisa.Vink@ontario.ca by April 15, 2014.

Grounds / Motifs :

1. Previously served August 2, 2013, as a Compliance Order

The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

A. The plan of care for resident #021 was not revised with changes in care needs. The resident was noted to have areas of altered skin integrity. Progress notes and staff interview identified that the resident was known to remove the dressings applied to protect and treat the skin. Progress notes identified that staff initiated a specified dressings in an effort to prevent additional trauma to the skin. The plan of care identified the altered skin integrity, however was not revised with the change in care needs related to the identified behaviour of the resident.
B. The clinical record for resident #021 identified family reports to staff that the resident experienced unusual symptoms on a specified date in 2014. Staff responded to these concerns with nursing measures to promote comfort. Interview with DOC's identified that a discussion was held with the family that same day, regarding the symptoms, and a decision was made that the resident would be assessed by the physician, the following day. The resident was not assessed as planned by the physician. Three days after the original concern was identified/discussed the physician was contacted and orders were received to treat a possible infection. Later that same day the resident experienced additional symptoms that required transport to hospital. The resident's plan of care was not revised with the changes in care needs and the physician was not contacted for three days, to treat the identified symptoms.
C. The plan of care for resident #003 was not reviewed and revised with changes in care needs. The resident previously utilized the services of the Behavioural Supports Ontario (BSO) and was discharged from the program. In January 2014, the resident was referred to the program due to an identified need. The current plan of care identified the resident had been referred to the BSO and Outreach Team in May 2013, and that they were discharged in July 2013 from the BSO. The plan was not updated when records indicated an increase in responsive behaviour and a referral back to the BSO and to the Outreach Team in January 2014. The DOC confirmed that the plan had not been updated with this change in need. [s. 6. (10) (b)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

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. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; 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. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
a) 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
b) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. Previously identified as a VPC August 2, 2013.

The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a Registered Dietitian who was a member of the staff of the home.

A. Resident #021 was noted to have altered skin integrity specifically: a skin tear was identified on August 8, 2013, which was resolved on August 30, 2013, and a second tear was identified on September 8, 2013, which was being treated into November, 2013. The RD did not assess the resident specifically related to the areas of altered skin integrity until November 14, 2013, at which time interventions were initiated to assist in wound healing, which was confirmed during an interview with RD and nursing staff.
B. Resident #205 had areas of altered skin integrity, specifically: a skin tear identified on January 24, 2014, a second skin tear identified on February 10, 2014, and a open area identified in February, 2014. Interview with the RD confirmed that she had not received a referral regarding these ongoing areas of altered skin integrity and for this reason the resident was not assessed for this identified need. [s. 50. (2) (b) (iii)]

The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Resident #021 had altered skin integrity which was not assessed weekly by the registered nursing staff.
i. The resident had a skin tear on August 9, 2013. This area was treated with a dressing and required the use of a topical cream before it was resolved on August 30, 2013. The area was included on the Treatment Administration Record and was consistently signed as being treated, however a documented

reassessment during the period of time between August 9, 2013, and August 30, 2013, was not available.
ii. The resident sustained a skin tear on September 8, 2013. This area was not reassessed weekly from September 9, 2013, until October 7, 2013, and November 18, 2013, until December 9, 2013.
iii. The resident sustained a cut on September 17, 2013. This area was identified in the progress notes when initially identified and treated however there was no further mention of the area in the clinical record.
B. Resident #205 was identified to have altered skin integrity.
i. The resident had a skin tear on January 24, 2014. A review of the clinical records and interview with the nursing staff confirmed that the area was not reassessed weekly by the nursing staff.
ii. The resident had a skin tear on February 10, 2014. A review of the clinical records and interview with the nursing staff confirmed that this area was not reassessed at least weekly between February 17, 2014, and March 6, 2014.
iii. The resident was identified to have an area of altered skin integrity in February 2014. A review of the clinical records and interview with the nursing staff confirmed that this area was not reassessed at least weekly between February 17, 2014, and March 6, 2014. [s. 50. (2) (b) (iv)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

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 21st day of March, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LISA VINK

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