Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 22, 2015	2015_188168_0010	H-002171-15	Resident Quality Inspection

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), CYNTHIA DITOMASSO (528), 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 31, April 1, 2, 7, 8, 9, 10, 14, 15 and 16, 2015.

The following inspections were completed concurrently with this RQI, Complaints and Critical Incident Inspections H-000734-14, H-001602-14, H-001914-15, H-00273-14, H-00914-14, H-002115-15, H-002038-15, H-001640-14, H-001553-14, H-001132-14 and H-00996-14 and Follow Up Inspections H-00452-14, H-00451-14, H-00388-14 and H-00461-14.

Any findings of non compliance identified during the identified concurrent inspections are included in this RQI Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DOC) , Assistant to the Director of Care, Admissions Coordinator, Social Service Worker (SSW), Program Manager, Food Service Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Quality Improvement Lead, maintenance staff, the Physiotherapist (PT), the Registered Dietitian (RD), dietary, housekeeping and laundry staff, Behavioural Supports Ontario (BSO) staff, registered nursing staff, personal support workers (PSW's), families and residents.

During this inspection, the inspectors toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: menus, meeting minutes, policies and procedures, logs, and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **14 VPC(s)**
- **2 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
O.Reg 79/10 s. 50. (2)	CO #005	2014_188168_0007	168

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 licensee failed ensure that the written plan of care for each resident set out the planned care for the resident.

On admission in 2013, resident #54 was identified as a high risk for falls. The resident had four documented falls from December 2013 to May 2014. Following each fall, the resident was assessed and progress notes indicated interventions staff were to implement including: keeping the resident close to the nursing station, call bell within reach, monitoring to prevent falls and using a chair alarm. In May 2014, the resident had an unwitnessed fall that resulted in a transfer to hospital. The resident returned from hospital approximately two weeks later; however, falls prevention interventions were not included in the resident's written plan of care until four days after their readmission to the home. The PT and registered nursing staff confirmed interventions were not included in the written plan of care when first initiated as being part of the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that the written plan of care for each resident provided clear directions to staff and others who provided direct care to the resident.

Resident #50 had a plan of care to receive pudding consistency thickened fluids. On March 31, 2015, during lunch, the resident consumed water which appeared to be nectar to honey thick. On April 2, 2015, during lunch, they were observed to consume Resource 2.0 and water, which appeared to be nectar thick. The diet list in the servery indicated the resident was to receive nectar thick water; however, did not specify a consistency for Resource 2.0. The lid on the resident's water glass identified nectar thick water; however, listed their fluid consistency as pudding. The RD confirmed the resident was to receive pudding thick fluids and water was to be a nectar consistency, as the plan of care did not provide clear direction. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A. Resident #74 had an identified behaviour of wandering, which provided an opportunity for negative interactions with a co-resident. Based on the actions of the co-resident, staff identified that they implemented interventions to redirect and monitor resident #74 away from the co-resident. A review of the relevant plan of care included a statement related to wandering; however, it did not include the specific interventions in place, based on a assessment, related to the need to redirect the resident away from the co-resident, as confirmed during a clinical record review with registered staff. The plan

was not based on the assessment of the resident and their needs.

B. The plan of care for resident #10 was not based on an assessment related to oral care. The plan identified that staff were to ensure that the upper denture was cleaned and in place at meal times. According to progress notes in 2015, the resident had their remaining teeth extracted. The resident confirmed the extraction and verbalized that they no longer had dentures. The March 15, 2015, MDS assessment identified that the resident had some or all natural teeth lost - did not have or did not use dentures. The plan of care was not reflective of the assessments completed, as confirmed during an interview with registered staff. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were consistent and complemented each other.

A. Resident #16 identified that they had some visual impairment and had not used glasses for a long time. The recent Minimum Data Set (MDS) assessments identified that the resident did not use glasses or corrective lens. The Head to Toe Assessment completed March 28, 2015, identified that the resident wore glasses for reading only. Interview with staff confirmed that the assessments were not consistent with each other related to use of eye glasses. (168)

B. Resident #10 was identified in the MDS assessment of March 15, 2015, to require total assistance of two staff for toileting and incontinence of bowel and bladder functioning. A review of the March 2015, Daily Resident Flowsheet, to be utilized as the observation period for the completion of the MDS assessment, identified that one staff was required to assist with toileting and that the resident was only frequently incontinent of both bowel and bladder function, which was consistent with PSW staff reports. A discussion with the RAI Coordinator confirmed that the Flowsheet was to be used in the completion of the MDS assessment and that the assessments were not consistent with each other. (168)

C. Resident #22 was noted to have a worsening area of altered skin integrity. In February 2015, a wound assessment completed by external registered staff identified the wound as unstageable; however, the Resident Assessment Protocol (RAP) completed later the same month identified the wound was stage III. Interview with the Wound Care Lead confirmed that the wound was greater than a stage III and that the RAP was not consistent with the wound care assessment completed earlier that month related to the

stage of the wound. (528)

D. The MDS assessment, dated January 18, 2015, indicated resident #17 had a diagnosis of a respiratory infection during the review period. Clinical records during this review period indicated the resident was being treated with antibiotics for an infection, other than respiratory. Registered staff confirmed the MDS assessment completed in January 2015, was not consistent with the other assessments completed. (585)

E. Resident #23 had areas of altered skin integrity when transferred to the hospital. The resident remained in the hospital for approximately two weeks and was reassessed on readmission to the home. The reassessment note identified that with the exception of a rash and redness to the feet, the resident's skin was dry and intact on return. Photographs taken by the Wound Care Lead two days later confirmed that the resident still had the initial areas of altered skin integrity. The Wound Care Lead confirmed that the reassessment completed on return from hospital was not consistent with other assessments of the resident related to skin and wound care. (168)

F. Resident #23 was coded as two healed stage IV ulcers during the August and November 2014, MDS assessments. A review of the assessment completed February 15, 2015, did not include information regarding the healed stage IV ulcers. Interview with the RAI Coordinator and Wound Care Lead confirmed that stage IV wounds were to be coded in the MDS assessments even when healed due to their previous presence/risk and that the most recent MDS assessment was not consistent with other assessments. (168)

G. Resident #23 was noted to have one stage II and one stage III ulcer during the MDS assessment conducted February 15, 2015. A review of the RAP completed for nutritional care, based on this assessment, identified that the resident received treatment for a stage II open area and did not include the presence of the stage III ulcer. The RAP was not consistent with the MDS assessment completed for the resident as confirmed during an interview with the RAI Coordinator and Wound Care Lead. [s. 6. (4) (a)]

5. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A. In February 2015, registered staff documented that resident #18 had a skin condition for which the physician ordered a topical treatment. Then March 2015, as a result of a

co-residents skin condition resident #18 received a preventative treatment. Review of the plan of care for resident #18 identified that their SDM made their care decisions; however, did not include any documentation that the SDM was notified of either of the new treatment orders. Interview with registered staff confirmed that they usually notified the resident or SDM of new orders; however, this was not completed for resident #18 in February and March 2015.

B. In February 2015, resident #13 was involved in an incident involving a co-resident which resulted in an area of altered skin integrity. A review of the plan of care identified that the SDM made care decisions. The record did not include documentation that the SDM was notified of the area of altered skin integrity. Interview with registered staff confirmed that they usually notified the SDM of new injuries; however, this not completed for the example identified. [s. 6. (5)]

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

A. The plan of care for resident #13 indicated that they requested assistance with cleaning dentures in the morning, after meals and before bed. On March 30 and April 2, 2015, between breakfast and lunch, the resident's teeth were observed to be unclean with food in the bottom denture. Interview with PSW staff on April 2, 2015, confirmed the resident was not assisted with denture cleaning after breakfast as outlined in the plan of care. (528)

B. The plan of care for resident #65 identified that they were visually impaired and directed staff to place commonly used items within reach and to identify location of commonly used items to ensure safety and security. On April 8, 2015, after dinner, the resident was escorted to their room and placed beside their bed, at which time, the PSW left the room. The call bell was observed to be on the opposite side of the bed and not within reach. Interview with resident confirmed they were unable to find their call bell. The PSW also confirmed that the resident was visually impaired and that the call bell was not in reach, as required in the plan of care. (528)

C. The plan of care for resident #67 identified that for safety staff were to ensure the call bell was with in reach. On April 8, 2015, the resident was transported to their room after dinner. They were placed beside the bed with the call bell positioned on the opposite side of the bed, not within reach. Interview with the resident confirmed they could not reach the call bell. Interview with registered staff confirmed the call bell was not within

the resident's reach, as required in the plan of care. (528)

D. The plan of care for resident #22 indicated that they had an area of skin breakdown and directed staff to offer and encourage them to elevate their affected limb in bed or the chair. On April 7, 2015, from 1100 to 1300 hours and 1400 to 1500 hours, the resident was observed sitting in their wheelchair and the limb was not elevated. During the observation staff did not offer nor encourage the resident to elevate the affected limb. Interview with PSW who was caring for the resident confirmed that the limb was not elevated as the resident usually refused and no additional encouragement was provided. Interview with the Wound Care Lead identified that with encouragement and education the resident would sometimes elevate the limb and staff were to encourage them to do so as clinically indicated in the plan of care. (528)

E. On October 22, 2014, a progress note identified that resident #53 was demonstrating responsive behaviours and suggested a referral to BSO. A review of the clinical record did not include a referral to BSO. Interview with regular BSO staff reported they did not receive a referral for the resident or communication with staff regarding the resident's behaviours until 2015. The DOC confirmed it was the expectation that referrals be completed on paper and included in the clinical records. The resident continued to demonstrate behaviours; however, a referral to BSO did not occur until March 2015. (585) [s. 6. (7)]

7. The licensee failed to ensure that when the resident was reassessed the plan of care was reviewed and revised at least every six months or whenever the resident's care needs changed.

A. Resident #61 displayed responsive behaviours including exit seeking and socially inappropriate behaviours. The resident was transferred out of the home for assessment and on readmission, interventions related to responsive behaviours included staff to complete a behaviour observation record (BOR), which required documentation of the resident's behaviours every 30 minutes. In February 2015, due to ongoing behaviours registered staff documented concerns for a co-resident's safety and as a result Dementia Observation System (DOS) charting would be continued to get a better understanding of the behaviours presenting. A review of the clinical record included the BOR/DOS charting from January 2015 to present date; however, the plan of care did not include this ongoing intervention despite this being an identified care need of the resident, as confirmed during an interview with registered staff. (528)

B. The plan of care for resident #66 identified that they were a high risk for falls and required an alarm when in the bed or chair and a bed falls mat. On the evening of April 8, 2015, the resident was observed in their wheelchair with no alarm in place. Interview with PSW and registered staff confirmed that the chair alarm was no longer necessary; however, the resident continued to require the alarm when in bed. The plan of care was not updated when the care set out in the plan was no longer necessary related to falls. (528)

C. Resident #15 had a change in condition and required increased assistance of staff as confirmed during family and staff interviews. A review of the plan of care noted that the resident required set up and supervision only at meal times and the use of one bed rail in bed. The resident was observed to be totally fed during the noon meal on April 2, 2015 and to have two bed rails raised when in bed on multiple occasions. Staff interviewed confirmed that due to changes in the resident they now required total feeding at meals and two bed rails when in bed for safety. Interview with the registered staff confirmed that the resident had a change in care needs and that the plan of care had not been revised to reflect this change as of April 10, 2015. (168)

D. The plan of care for resident #71 included an intervention to meet with the SSW daily at approximately 1000 hours, to discuss any ongoing issues with frustration. This intervention was included into the plan in 2012. Interview with the SSW, who began employment in the home in 2013, identified that she did visit with the resident routinely; however, not daily. Registered staff interviewed identified that at the time that the intervention was included into the plan of care there must have been an identified need, which has since resolved. It was confirmed that the plan of care was not revised with changes in care needs or when the care was not longer necessary. (168)

E. The plan of care for resident #13 indicated that they had corrective lenses and directed staff to ensure that the glasses were clean and used by the resident. From March 30 to April 1, 2015, the resident was observed without glasses. The PSW identified that the resident had not had their glasses for sometime and they could not be located. The plan of care was not updated when the resident care needs had changed related to the use of glasses as confirmed during an interview with registered staff. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 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 the written plan of care sets out the planned care for the resident, that the plan of care provides clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were consistent and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was respected.

On April 8, 2015, at approximately 1740 hours, staff were observed escorting residents to and from the dining room for second seating dinner service. At 1810 hours, resident #67 was observed sitting in the lounge. Review of the plan of care identified that they were on second seating and required the assistance of one staff to push the wheelchair as they were unable to self propel. Interview with staff in the dining room, at that time, indicated that second seating residents were in the dining room and all resident's had their entrees. When the staff were asked about resident #67, they realized that the resident was not in dining room and they quickly escorted them from the lounge to their dining table. Staff were overheard apologizing to the resident for forgetting about them after the meal service. The resident's right to be cared for in a manner with their needs was not respected on April 8, 2015. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A. The home's program, Fall Prevention Program, last revised April 2010, was not complied with. The Fall Prevention Program identified that a "post fall assessment is done at a minimum every shift for the following twenty-four (24) hours for potential complications from the fall", that "this assessment is documented in the electronic interdisciplinary notes" and that "the resident will be assessed after each fall using the Risk Incident Assessment", and "information is entered in the Risk Management Section of PCC for both a fall and near misses".

i. Resident #54 was identified to be at a high risk for falls and had four documented falls from December 2013 to May 2014. A review of the clinical record did not include completed post fall assessment documentation every shift for a minimum of 24 hours, for the first, second, and third fall. Interview with registered staff confirmed that the assessments were not documented as required and confirmed that the documentation was to be completed each shift for the first 24 hours in the progress notes.
ii. Resident #54 experienced a near miss fall in December 2013, a fall in December 2013, and a fall in May 2014. There was no Risk Incident Assessment documented for these incidents. Registered nursing staff confirmed that the Risk Incident Assessment was expected to be completed for near misses and falls and that they were not completed as required. (585)

B. The home's policy Narcotics/Controlled Substances, RCS F-30, last revised July 15, 2013, identified that "the registered staff on duty and the registered staff coming in for duty will jointly count narcotics/controlled substances at shift change".

On January 21, 2015, it was identified that the home was missing, a 28 tablet card of a narcotic. The home's internal investigation identified that not all staff consistently completed the narcotic counts as per the home's policy from January 19 until 21, 2015, which was confirmed during staff interviews. [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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure resident #52 was protected from abuse.

i. In October 2014, resident #53 abused resident #52. Resident #52 was identified to be aware and upset following the incident as confirmed by the clinical record and staff interview.
ii. In November 2014, resident #53 abused resident #52. Resident #52 was identified to be aware and upset following the incident as confirmed by the clinical record and staff interview.
iii. In November 2014, staff observed resident #53 exit resident #52's room in the middle of the night. Clinical documentation indicated that resident #52 reported to staff that they were touched, as confirmed during staff interview.

The DOC confirmed the occurrences listed above were considered abuse. The licensee failed to ensure the resident was protected from abuse. [s. 19. (1)]

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 all residents are protected from abuse, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. Resident #70 was noted to be frequently incontinent and used pull ups during waking hours and a brief at night. Staff were to assist the resident with toileting between 1600 and 1700 hours and again between 2200 and 2300 hours, and document this care on the Daily Resident Flowsheet. The resident reported that assistance was not provided with toileting on March 1, 2014, for an extended period of time. A review of the Flowsheet for March 2014, did not include staff documentation of any interventions attempted or provided to the resident related to toileting activities between 1600 and 1700 hours or 2200 and 2300 hours, as confirmed during an interview with registered staff when the Flowsheet was reviewed. (168)

B. A review of the clinical record identified that resident #74 was involved in two separate incidents involving a co-resident in the summer of 2014. Staff interviewed were aware of the incidents and identified actions taken by the home, including monitoring and redirection of the resident, in an effort to prevent recurrence. A review of the clinical

record did not include documentation of a reassessment of the resident following the incidents, nor the interventions and the resident's response, for the shifts immediately following, as confirmed during an interview with registered staff. (168)

C. The plan of care for resident #11 identified that they had chronic wounds which required interdisciplinary involvement and treatment. A review of the electronic Treatment Administration Record (eTARS) from December 2014 to March 22, 2015, did not include wound treatment documented as completed on approximately twenty two days. Interview with the Wound Care Lead and registered staff indicated that staff completed the treatment as ordered but did not document this care in the eTARS. (528)

D. Resident #23 had multiple areas of skin breakdown, at various stages, which were to be assessed weekly by a member of the registered nursing staff. A review of the clinical record did not include assessments of the areas for the period of time between February 8, 2015 and February 26, 2015. Interview with the Wound Care Lead identified that these assessments were completed weekly, over the identified time period and was able to provide photographs of the areas of skin breakdown taken on February 11, 19 and 26, 2015. The process of wound assessments was explained as, the resident was assessed, photographs of the wounds taken and rough assessments notes recorded. Formal and complete assessments were then to be recorded in the electronic record. The Wound Care Lead confirmed that the assessments completed on February 11, 19 and 26, 2015, were not documented as required; however, had been completed. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions, are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Resident #16 had natural teeth and identified that staff only completed oral care once a day in the morning. During the evening shift on April 8, 2015, the resident was provided care and positioned into bed by staff. When questioned staff confirmed that they had completed bedtime care for the resident and that this care did not include any assistance with oral hygiene. Staff indicated that oral care was completed by the resident independently. The staff then offered and completed the care to the resident. A review of the plan of care included direction for staff to assist with oral care, at a minimum, to set up the supplies as well as to provide extensive assistance. Oral care was not provided to the resident in the evening. [s. 34. (1) (a)]

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 oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.

WN #7: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

The plan of care for resident #66 indicated that they had a history of skin breakdown and required extensive assistance of two staff for transferring and positioning. On April 8, 2015, the resident was observed sitting upright in a wheelchair, from 1330 until 1910 hours. Staff did not reposition the resident until they were assisted to bed at 1910 hours. Interview with PSW confirmed that the resident was dependent on staff and they were not repositioned for over five hours. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #8: 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 :

1. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A. Resident #73 demonstrated responsive behaviours in the summer of 2014, which impacted a co-resident. As a result of the behaviours the home initiated a number of interventions, following an incident, in an effort to prevent recurrence. A review of the clinical record did not include documentation the shifts following the incident, nor a record of the resident's response to the interventions. Staff interviewed confirmed knowledge of the behaviour and confirmed that interventions were taken; however, were unable to provide documentation of the of the reassessments and responses to interventions. (168)

B. Resident #61 displayed ongoing responsive behaviours on admission to the home, which included exit seeking and socially inappropriate behaviours. The resident was transferred out of the home for assessment in 2015. On readmission interventions included one to one monitoring and directed staff to complete a behaviour observation record (BOR), which consisted of documenting behaviours every 30 minutes. A review of the behavioural charting from January to March 2015, identified that the BOR was not consistently documented. Interview with PSW and registered staff confirmed that the behaviours were not documented every 30 minutes, as required.

C. Resident #53 demonstrated responsive behaviours and the plan of care identified that staff were to "continue to complete the behavioural observation record (BOR)". The resident's BOR was reviewed from March 1-15, 2015 and 12 of these days had incomplete documentation. A PSW and the DOC confirmed that the BOR was to be completed every 30 minutes and confirmed that the documentation was not completed when the observations were completed. (585)

D. Resident #72 had a history of responsive behaviours. In an effort to manage these behaviours the home utilized the resources of external consultants who made a number of suggestions which were trialed and included into the plan of care. Interviews with staff who were familiar with the resident confirmed that the interventions, including documenting meal choices, consistent responses to statements, reduction in the use of 1:1 staffing and a medication log were trialed, some with success and others without. A review of the clinical record did not consistently include the use of the interventions and/or the resident's response, as confirmed with registered staff. (168) [s. 53. (4) (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 actions taken to meet the needs of the resident with responsive behaviours include assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 31, 2015, during the second floor lunch meal, pureed peas and mashed potatoes were served to residents. Both items appeared runny and pooling on the plates. The dietary aide present confirmed that the items appeared runny. The FSM confirmed that pureed food should hold shape and not be runny, to preserve appearance. The runny consistency of the potatoes and peas compromised their nutritive value, appearance and food quality. [s. 72. (3) (a)]

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 food in the food production system are prepared, stored and served using methods to preserve nutritive value, appearance and food quality, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menu was communicated to residents.

On March 31, 2015, during the second floor lunch meal, the posted daily menu and what was served did not reflect the seven day menu that was posted in the hallway. The FSM confirmed the posted weekly menu was incorrect and not reflective of the meal served. [s. 73. (1) 1.]

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 weekly menu is communicated to residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. In November 2014, a written letter was submitted to the home with concerns related to the care of resident #60. Although an internal investigation was initiated immediately, a review of the Complaint/Concern Log did not include the written complaint, or a record of dates, actions, or responses within relation to the complaint letter. Interview with the DOC confirmed that the written complaint letter was not recorded in the Complaint/Concern Log.

B. In April 2014, the family of resident #15 expressed concerns related to missing items and a specific item was documented in the clinical health record. Then in November 2014, resident #16 also expressed concerns related to missing items. These items were recorded in the clinical health record. A review of the Complaint/Concern Log did not include the concerns from resident #15 or #16.

Interview with the SSW identified that complaints/concerns, including but not limited to, missing items were to be documented on a Client Service Response Form for follow-up and logged on the home's Complaint/Concern Log. The SSW confirmed that the missing items for residents #15 and #16 were not documented on the Client Service Response Form or recorded on the Complaint/Concern Log. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes: the nature of each verbal or written complaint, the date it is received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response is provided to the complainant and a description of the response and any response made by the complainant, 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 failed to ensure that drugs were stored in a medication cart which was secure and locked.

A. The home identified on January 21, 2015, that they were missing a 28 tablet card of a narcotic. It was identified during an internal investigation that not all registered staff consistently locked their medication cart when the cart was not in a secured location or under constant supervision. Staff interviews confirmed that there was at least one occasion where drugs, including the missing narcotics, were in an unsecured medication cart between January 19 and 21, 2015.

B. On April 8, 2015, from 1329 hours until 1400 hours, 16 insulin pens, with cartridges, were located at the nursing station on the third floor in a basket on a computer cart. This basket also contained a large quantity of clean pen needles. The nursing station was unlocked and there were no registered staff in attendance. At 1400 hours the registered staff returned to the unit and confirmed that the insulin pens were medications and that they should be secured and locked at all times. [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The home identified on January 21, 2015, that they were missing a 28 tablet card of a narcotic. It was identified during an internal investigation that the narcotic was stored in the separate area in the medication cart; however, not all registered staff consistently locked the area or the medication cart when the cart was not in a secured location or under constant supervision. It was confirmed during staff interviews that there was at least one occasion where the missing narcotics, were in a unlocked unsecured area between January 19 and 21, 2015. [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 drugs are stored in a medication cart which is secure and locked and that controlled substances are 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. 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 for the resident taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs.

The home's Pain Management Policy, last revised July 2013, indicated that residents on scheduled pain management medications would have a monthly evaluation summary completed to evaluate pain control measures and the effectiveness of pain medications.

A. Resident #11 was identified to have had ongoing pain with opioid dependence and received regular scheduled pain medication. Changes in pain medications were ordered by the physician in December 2014 and February 2015. The resident's record did not include monthly evaluation summaries to evaluate pain control measures and the effectiveness of pain medications after November 2013, nor did it include completed Pain Management Flowsheets following a change in pain medication. Interview with registered staff confirmed that pain control for the resident was challenging. The RAI Coordinator confirmed that the Pain Management Flowsheets were not utilized by staff following a change in pain medication and monthly evaluation summaries were not completed to evaluate pain control measures after November 2013.

B. Resident #60 had ongoing pain related to chronic disease and multiple fractures. Changes in regularly scheduled pain medication were ordered in September, November and December 2014.
The record did not include monthly evaluation summaries to evaluate pain control measures and effectiveness of pain medications after August 2014, nor did it include completed Pain Management Flowsheets following changes in pain medication for September and December 2014. The RAI Coordinator confirmed that the Flowsheets were not utilized by staff following a change in pain medication in September and December 2014 and monthly evaluation summaries were not completed to evaluate pain control measures after August 2014 [s. 134. (a)]

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 for the resident 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, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record was kept up to date at all times.

A. The plan of care for resident #60 identified that they had responsive behaviours and required DOS charting to be completed every thirty minutes. The DOS charting completed from December 2014 to March 2015, was recorded manually on paper forms. Four out of the sixteen forms were noted to have numbers corresponding to days of the month, but did not include the month or the year. The record was not kept up to date and it was unclear when specific observations were made, as confirmed during an interview with registered staff.

B. On admission, resident #18 was identified as frequently incontinent of bladder, required assistance of staff and used a continent care product. The Voiding Diary/Assessment located in the resident's record did not include the date that the assessment was completed. Interview with the DOC confirmed the Diary was not kept up to date with a documented assessment date; however, noted that since there had not been a change in the resident's continence level the assessment would have been completed on admission. [s. 231. (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 the resident's written record is kept up to date at all times, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's abuse policy, Resident Rights - Abuse or Neglect Policy, Index I.D: RCS P-10, revised January 10, 2014, stated "on becoming aware of abuse or neglect, suspected abuse or neglect, the person first to have knowledge of this shall immediately inform the Director at the MOHLTC and the Director of Nursing/or Delegate or if not available, the Administrator".

A. Documentation revealed that a registered nursing staff was informed of an allegation of abuse toward resident #21. The staff immediately submitted a letter to the DOC regarding the allegation. Documentation identified that the letter was not received by the DOC until 12 days later. The staff confirmed that they had not informed the Director or the home's management team immediately. The DOC confirmed they were not aware of the allegation immediately and that the incident should have been reported to the Director as required.

B. According to the clinical record staff observed resident #53 touch resident #52 in a manner that was considered abuse and was upsetting to the resident on a specified date in 2014, at 1730 hours. This incident was not reported to the Director until the following day at 1543 hours, utilizing the Critical Incident System. Interview with both the registered staff who was present during the incident and the DOC confirmed that the incident was not reported immediately as required. [s. 20. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been approved by: a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations and that the device had been consented to by the resident or a substitute decision-maker of the resident with authority to give that consent.

Resident #15 was assessed in January 2015 and had a plan of care in place for the use of one bed rail when in bed as a Personal Assistance Services Device (PASD). The resident was monitored and was noted on multiple occasions, including on April 1, 2015, to be in bed, with two bed rails in the raised position. Interview with registered staff on April 14, 2015, confirmed that due to a change in the resident's condition they now required two rails when in bed. A review of the clinical record, with the registered staff, did not include an assessment/approval of the device or consent for the revised use of the PASD, as two rails. [s. 33. (4) 3.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that they complied with the Act when they refused an applicant's admission to the home based on reasons that were not permitted within the legislation.

A. In October 2014, the home refused admission application for applicant #62. The letter indicated that the home was unable to accept the applicant due to responsive behaviours and that they were not on a smoking cessation program.
i. On December 4, 2014, the home was contacted by the ministry and they agreed to re-review the application. A second letter dated December 4, 2014, refused admission due to responsive and smoking behaviours.
ii. Interview with the DOC on April 7, 2015, confirmed that the current resident population included both responsive and smoking behaviours which staff were able to safely manage.
The behaviours identified, by the home, in the October and November 2014, refusal letters were not outside the staff expertise and were not in compliance related to refusal of admission, as identified in the Act.

B. In June 2014, the home refused admission application for applicant #63. The letter indicated that the home was unable to accept the resident due to persistent anger and wandering aimlessly. Interview with the DOC on April 7, 2015, confirmed that the current resident population had responsive behaviours, including but not limited to persistent anger and wandering and that staff were able to safely manage the behaviours. The responsive behaviours, described by the home, in the letters, were not outside of the staff expertise. The letter from June 2014, did not meet compliance related to refusal of admission, as identified in the Act. [s. 44. (7)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, followed by the report of an injury in respect of which a person is taken to hospital.

Resident #54 had an unwitnessed fall and was transferred to hospital. A review of clinical documentation revealed that the following day, the home was in contact with the hospital and informed that the fall resulted in a fracture. A Critical Incident Report was not submitted to the Director until four days after the fracture was communicated to the home. The DOC confirmed the resident's injury resulted in a significant change and a report was not submitted to the Director within one business day as required. [s. 107. (3) 4.]

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), CYNTHIA DITOMASSO (528), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_188168_0010
Log No. / Registre no:	H-002171-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 22, 2015
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:

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: 2014_188168_0006, CO #002;

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 prepare, implement and submit a plan to ensure that all residents are provided care as specified in their plans of care specifically related to: oral care, accessibility of call bells, positioning, and referrals to external consultants.

This plan shall include but not be limited to:
A. A system to communicate to staff and others responsible for providing care to the residents the needs of the residents as identified in their plans of care.
B. Clearly defined roles for staff so that they are aware of their responsibilities in the care of the resident's needs as per their plans of care.
C. Ongoing audits and other quality activities to ensure that the care set out in the plans of care are provided to the residents as specified.

The plan is to be submitted to Lisa.Vink@ontario.ca on or before May 1, 2015.

Grounds / Motifs :

1. Previously served as a CO May 2013 and February 2014.

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

A. The plan of care for resident #13 indicated that they requested assistance with cleaning dentures in the morning, after meals and before bed. On March 30 and April 2, 2015, between breakfast and lunch, the resident's teeth were observed to be unclean with food in the bottom denture. Interview with PSW

staff on April 2, 2015, confirmed the resident was not assisted with denture cleaning after breakfast as outlined in the plan of care. (528)

B. The plan of care for resident #65 identified that they were visually impaired and directed staff to place commonly used items within reach and to identify location of commonly used items to ensure safety and security. On April 8, 2015, after dinner, the resident was escorted to their room and placed beside their bed, at which time, the PSW left the room. The call bell was observed to be on the opposite side of the bed and not within reach. Interview with resident confirmed they were unable to find their call bell. The PSW also confirmed that the resident was visually impaired and that the call bell was not in reach, as required in the plan of care. (528)

C. The plan of care for resident #67 identified that for safety staff were to ensure the call bell was with in reach. On April 8, 2015, the resident was transported to their room after dinner. They were placed beside the bed with the call bell positioned on the opposite side of the bed, not within reach. Interview with the resident confirmed they could not reach the call bell. Interview with registered staff confirmed the call bell was not within the resident's reach, as required in the plan of care. (528)

D. The plan of care for resident #22 indicated that they had an area of skin breakdown and directed staff to offer and encourage them to elevate their affected limb in bed or the chair. On April 7, 2015, from 1100 to 1300 hours and 1400 to 1500 hours, the resident was observed sitting in their wheelchair and the limb was not elevated. During the observation staff did not offer nor encourage the resident to elevate the affected limb. Interview with PSW who was caring for the resident confirmed that the limb was not elevated as the resident usually refused and no additional encouragement was provided. Interview with the Wound Care Lead identified that with encouragement and education the resident would sometimes elevate the limb and staff were to encourage them to do so as clinically indicated in the plan of care. (528)

E. On October 22, 2014, a progress note identified that resident #53 was demonstrating responsive behaviours and suggested a referral to BSO. A review of the clinical record did not include a referral to BSO. Interview with regular BSO staff reported they did not receive a referral for the resident or communication with staff regarding the resident's behaviours until 2015. The DOC confirmed it was the expectation that referrals be completed on paper and

included in the clinical records. The resident continued to demonstrate behaviours; however, a referral to BSO did not occur until March 2015. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant:
2014_188168_0007, CO #004;
2014_300560_0007, CO #001;

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, implement and submit a plan to ensure that the plans of care for all residents are reviewed and revised with changes in the resident's care needs or when the care is no longer necessary specifically related to: interventions required related to changes in level of assistance required for activities of daily living, use of corrective lenses, responsive behaviours, bed rail usage and falls management.

This plan shall include but not be limited to:
A. A system to communicate to staff and others responsible for providing care to the residents changes in care needs and when care is no longer necessary.
B. Clearly defined roles for staff so that they are aware of their responsibilities in relation to reviewing and revising the plans of care.
C. Ongoing audits and other quality activities to ensure that the plans of care are update and reviewed and revised as required.
D. Education to staff regarding the purpose of the plan of care and how and when to utilize and modify this document to meet the care needs of the residents.

The plan is to be submitted to Lisa.Vink@ontario.ca on or before May 1, 2015.

Grounds / Motifs :

1. Previously serve as a CO May 2013, February 2014 and May 2014.

The licensee failed to ensure that when the resident was reassessed the plan of care was reviewed and revised at least every six months or whenever the resident's care needs changed.

A. Resident #61 displayed responsive behaviours including exit seeking and socially inappropriate behaviours. The resident was transferred out of the home for assessment and on readmission, interventions related to responsive behaviours included staff to complete a behaviour observation record (BOR), which required documentation of the resident's behaviours every 30 minutes. In February 2015, due to ongoing behaviours registered staff documented concerns for a co-resident's safety and as a result Dementia Observation System (DOS) charting would be continued to get a better understanding of the behaviours presenting. A review of the clinical record included the BOR/DOS charting from January 2015 to present date; however, the plan of care did not include this ongoing intervention despite this being an identified care need of the resident, as confirmed during an interview with registered staff. (528)

B. The plan of care for resident #66 identified that they were a high risk for falls and required an alarm when in the bed or chair and a bed falls mat. On the evening of April 8, 2015, the resident was observed in their wheelchair with no alarm in place. Interview with PSW and registered staff confirmed that the chair alarm was no longer necessary; however, the resident continued to require the alarm when in bed. The plan of care was not updated when the care set out in the plan was no longer necessary related to falls. (528)

C. Resident #15 had a change in condition and required increased assistance of staff as confirmed during family and staff interviews. A review of the plan of care noted that the resident required set up and supervision only at meal times and the use of one bed rail in bed. The resident was observed to be totally fed during the noon meal on April 2, 2015 and to have two bed rails raised when in bed on multiple occasions. Staff interviewed confirmed that due to changes in the resident they now required total feeding at meals and two bed rails when in bed for safety. Interview with the registered staff confirmed that the resident had a change in care needs and that the plan of care had not been revised to reflect this change as of April 10, 2015. (168)

D. The plan of care for resident #71 included an intervention to meet with the SSW daily at approximately 1000 hours, to discuss any ongoing issues with frustration. This intervention was included into the plan in 2012. Interview with the SSW, who began employment in the home in 2013, identified that she did visit with the resident routinely; however, not daily. Registered staff interviewed identified that at the time that the intervention was included into the plan of care there must have been an identified need, which has since resolved. It was confirmed that the plan of care was not revised with changes in care needs or when the care was not longer necessary. (168)

E. The plan of care for resident #13 indicated that they had corrective lenses and directed staff to ensure that the glasses were clean and used by the resident. From March 30 to April 1, 2015, the resident was observed without glasses. The PSW identified that the resident had not had their glasses for sometime and they could not be located. The plan of care was not updated when the resident care needs had changed related to the use of glasses as confirmed during an interview with registered staff. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of April, 2015

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