Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2017	2017_531518_0006	003337-17	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

ALISON FALKINGHAM (518), ADAM CANN (634), ALICIA MARLATT (590), AMIE GIBBS-WARD (630), CHRIS LAIDLAW (668)

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): February 6, 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2017.

Within this RQI one complaint and several critical incidents were completed:
Log 007909-16 a critical incident related to falls
Log 022616-16 a critical incident related to falls
Log 027620-16 a critical incident related to falls
Log 029434-16 a critical incident related to abuse
Log 029682-16 a critical incident related to falls
Log 026981-16 a critical incident related to falls
Log 020462-16 a complaint related to improper care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), two Assistant Directors of Care(ADOC), seven Registered Nurses(RN), five Registered Practical Nurses(RPN), the Programs Manager, the Wound Care Champion, the Dietitian, two Physiotherapists, the Social Worker, the Resident Assessment Instrument Minimum Data Set(RAI MDS) Co-ordinator, 13 Personal Support Workers(PSW), the Maintenance Supervisor, a restorative aide, 40 residents and three resident family members.
The inspectors also toured the home for general cleanliness and condition, observed a meal service and a medication administration pass, reviewed 40 resident records, observed recreational activities, reviewed the home's policies and observed general staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) This inspection was inspector initiated as a result of safety concerns observed by two Inspectors that found a resident was using two medical devices designed for safety where one of these devices were not applied properly.

A staff member told the Inspector that the resident used this medical device for safety as this resident would tend to move around in the medical device and slide down.
A staff member acknowledged the device was applied loosely and said the device was not considered a restraint as the resident could undo the device at will. In the presence of the Inspector, the staff member asked the resident if they could undo the device and the resident was able to undo the device.

A different staff member said they were unsure if the resident used that medical device. The staff member reviewed the electronic chart, the plan of care and the hard copy chart in the presence of the Inspector and did not see any documentation regarding the use of

the medical device for this resident. The staff member observed the resident with the Inspector and acknowledged this resident was wearing a medical device and it was loose.
The staff member asked the resident if they could undo the medical device and the resident was able to follow the instruction. The staff member told the Inspector that they therefore did not consider this to be a restraint.

The DOC and ADOC said it was the expectation that these medical devices would be included in the plan of care for residents based on an assessment of the intended purpose of the device. The ADOC said it was the expectation in the home that if a resident preferred to have the medical device applied loosely then it would be assessed and identified in the plan of care. The DOC reviewed the plan of care for the resident and acknowledged the medical device was not included as an intervention. The DOC said it was the expectation in the home that the plan of care would provide clear direction for staff regarding the use of these medical devices.
(630)

B) This inspection was inspector initiated as a result of safety concerns observed by the Inspector of a resident who was using two medical devices, one of the devices was applied very loosely with the closure resting on the resident's knees.
During another observation the resident had the medical device in place applied in an appropriate manner during an entertainment event. The resident stated they apply the medical device in the morning and remove it at night. The resident's family member stated they wanted the medical device applied daily by the staff due to the resident's memory problems and that they had told the staff of this request previously.

The clinical record review did not indicate that a medical device was used in the Minimum Data Set (MDS), no assessments were completed for the use of a medical device.
The purpose for the device's use was not included in the most recent care plan. Two staff members stated they were unaware why the resident was using the medical device.

The DOC reported that the medical device should have been included in the plan of care and that their expectation was that medical devices were assessed, monitored, documented and included in the plan of care so clear directions are set out to the staff who provide care to the resident.
(518)

C) A resident was observed to have a bed rail raised on the left side of the bed on three separate days.
Interviews with three staff members stated that the resident used this bed rail for repositioning in bed and assisting with transferring into the standing position.
The most recent MDS stated that the resident used other types of medical devices daily.
The most recent care plan did not mention the bed rails, its purpose or any assessments.

The home's policy RCS E-05 Bed Rails last revised August 10, 2013, stated:
5. Bed rail use for mobility and/or transferring, for example turning and positioning within the bed and providing a hand hold for getting into and out of bed,
should be accompanied by a care plan.
The resident should be encouraged to participate in care planning to help design a safe and comfortable environment.
The care plan should:
Include educating the resident about the bed rail danger to enable the resident to make an informed decision; and
Address options for reducing the risks of the rail use.

The ADOC and DOC stated that the plan of care did not include the use of this medical device and the expectation was that medical devices used as a PASD for bed mobility and transferring should have been included in the care plan. (518)

D) Observations on two separate days by an Inspector found a resident had one bed rail in the raised position on the left side of the bed.

A staff member reported that they thought the resident used this bed rail to help prevent them from falling out of bed and for positioning themselves when in bed.
A staff member told the Inspector that they were unsure which medical devices the resident used.
In the presence of the Inspector, a staff member asked a co-worker and then said that the resident used two medical devices.
The staff member said that they thought the bed rails were used to help prevent the resident from falling out of the bed.
A staff member reviewed the plan of care with the Inspector and discovered that these medical devices had not been included in the care plan.

The DOC and ADOC said it was the expectation that the plan of care would provide clear

direction for staff regarding the use of the medical devices for the resident.

The severity of this issue was determined to be level two with minimal harm or potential for actual harm to the residents. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 15, 2016, as a Voluntary Plan of Correction(VPC) during the RQI 2016_276537-0012, September 23, 2015, as a VPC in a complaint inspection 2015_276537_0038, August 25, 2015, as a VPC in a complaint inspection 2015_257518_0046, and April 14, 2015 as a VPC in the Resident Quality Inspection 2015_216144_0019.
(518) [s. 6. (1) (c)]

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

A) During stage one of the Resident Quality Inspection a complaint was verbally received from family members that the care needed was not being provided as specified to a resident.

The resident returned to the home with two medical devices in place.

The resident has a medical device that required continuous monitoring by staff.

The resident's care plan stated the goal for the resident was to remain free of diagnosis related symptoms or complications. Outlined interventions identified the staff are to “assess, record & report to MD any symptoms which could indicate the medical device was not working properly.

A progress note completed by a registered staff member stated that when they arrived for their shift the resident was agitated and displayed facial grimacing. Upon assessment it was observed that the resident's medical device was not functioning properly. The staff member intervened appropriately and the resident was relieved from discomfort with the medical device functioning properly.

During an interview with the Administrator, they shared that they were aware of this incident and had completed an internal investigation. They found that the responsible nurse did not appropriately assess the resident’s medical condition as outlined in the plan of care. The nurse was disciplined as a result.

B) A resident's care plan stated the resident's medical device was to be operated at specific times daily.

A progress note entry made by staff stated that the resident's medical device was not initiated until a specific time. The note stated the delay in starting the device was related to staffing issues at the beginning of their shift. A progress note entry made by staff stated that the family was visiting and the medical device was being operated earlier than the scheduled time. The note stated that the medical device had been initiated at a time nine hours before the device was scheduled to start. A progress note entry stated that the homes Registered Dietitian completed an assessment of the resident and that the medical device would resume that night at the scheduled time. During an interview with a staff member they shared that they were aware of the medical device's schedule for the resident and was able to provide the correct schedule to the Inspector.

In an interview with the DON and the Administrator they shared that the care was not provided as outlined in the plan of care.

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

The severity of this issue was determined to be a level two as there was minimal risk of harm or potential for actual harm.
The scope of this issue was determined to be isolated during the course of this inspection.
The home does not have a history of non compliance in this subsection of the legislation. (518) [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of a resident's care plan in Point Click Care was completed and it stated two medical devices were to be checked to ensure they were in place.

Observation of the resident was conducted and the medical device was not in place as described the care plan.

An interview was completed with a staff member who said that the resident no longer required the device and the intervention was discontinued. The staff member said that the staff would check the Kardex on Point of Care for fall interventions. An interview was completed with a staff member who said that if a resident was not to have a medical device they would not expect to see it in the residents plan of care.

The staff member checked the resident's care plan in Point Click Care and stated the intervention was in the care plan but it should not be.

An interview was conducted with the DOC who said that the plan of care should be updated when interventions are no longer required.

The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The severity of this issue was determined to be level two with minimum risk of harm to potential for actual harm to the residents. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 24, 2016, as a VPC in a complaint inspection 2016_276537_0015. (634) [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 resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A resident had two altered areas of impaired skin integrity.

Review of the resident's plan of care showed that the resident required specific medical care and comfort measures during day, evening and night shifts which required documentation in the computerized record daily.

Interviews with three staff members stated that on evening shift and night shift the staff are to ensure that the resident received care as ordered and the registered staff member was to sign the electronic treatment record (etar) that this had been completed at the end of the shift.

Review of the etar showed that on twenty nine occasions no documentation had taken place related to these treatments on evening and night shift when the resident was in bed.

The ADOC stated the expectation was that the evening and midnight registered staff should have ensured the treatments had been completed and signed the etar at the end of the shift confirming it was done.

B) A resident had two areas of compromised skin integrity which required treatments every two days as directed by the physician, to be completed by the registered staff and documented when completed.

Review of the resident's electronic treatment administration record(etar) showed there was missing documentation for both areas on five separate days in a one month period.

Review of the resident progress notes showed that the resident had removed and refused the treatments on one occasion. There were no progress note entries made about the residents treatments being addressed on occasion. There was a progress note indicating the physician was in and had completed the treatment that day for both the resident's compromised skin areas. On one occasion there were two progress notes made about the treatment for one area being completed.

Review of the home's policy titled "Electronic Documentation", Index I.D: RCS C-10-05, last revised July 15, 2013 directs the staff that electronic documentation "Entries should include but not be limited to: Any refusal of medications or treatments."

An interview with a staff member stated that the resident often refused these treatments on weekends with newer staff members. They further explained, that may be why there were no signatures for the treatments on the indicated days as those are all weekend days. They also explained that the staff should be documenting on the etar if the resident refused the treatments. They stated that on three occasions, emails were sent out to all registered staff to remind staff to provide care on the weekends per physician's orders and document that care in the etar.

In an interview the DON agreed that there was missing documentation on the resident's etar on the identified dates. They said that all staff should be documenting residents treatments, including refusal of treatments and that the home's policy also outlines this expectation.

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

The severity of these issues was determined to be level two with minimum risk of harm to potential for actual harm to the resident. The scope of this issue was isolated during the course of the inspection. There was a compliance history of this legislation being issued in the home on May 15, 2016, as a VPC in the RQI 2016_276537_0012. [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 assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

(f) any response made by the complainant

A resident was admitted to the long-term care home with two personal medical devices. During a family interview it was reported that the resident's two personal medical devices had gone missing for the second time since the resident's admission.

Review of the resident's clinical record showed that a staff member noticed that the resident was missing these devices, a search was conducted by the staff at that time, the items were not found and the Power of Attorney was contacted by telephone. The Administrator and the former DOC also went and searched the floor, the resident's room and laundry for the missing items. Again they were not found and the Power of Attorney was notified by telephone.

Interview with Administrator and Social Worker(SW) indicated they were aware of the concern regarding the missing items. The SW stated that the resident's family had spoken to them on the phone and expressed concern over the missing items and the fact that this had been the second time it had happened. The Administrator stated that the staff member or SW should have completed a CSR report when the items were noted to be missing, when the family expressed concerns and there should have been initial and ongoing follow up with the family regarding this complaint.

The home's policy Client Services Response Form(Complaint Investigation) LGM I-10 last revised June 30, 2014 stated:
Standard
1. A Client Service Response Form is to be completed by any person receiving a complaint or concern
Procedure
1. It is the responsibility of the person receiving a complaint/concern to document the information on a "Client Services Response Form". All sections on the form are to be completed. The completed form will be forwarded to the Social Service Coordinator within 72 hours.

The Administrator stated that all complaints or concerns should be documented on a CSR form including the nature of each verbal complaint, the date the complaint 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 by the

staff member who became aware of the concern or complaint.

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

The severity of this issue was determined to be level two with minimal harm or potential for actual harm to the resident. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of legislation. [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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

During an interview with a resident who is a member of the Residents' Council, it was reported that they were unsure whether the Residents' Council had been involved in developing the satisfaction survey or aware of the results.

During an interview with the Programs Manager(PM) it was reported that the Residents' Council had not been involved in the development or review of the satisfaction survey results over the past year. In the presence of the inspector, PM reviewed the Residents' Council meeting minutes for the last year and was unable to find documented evidence of council participation in the satisfaction survey or survey results.

During an interview with Administrator it was acknowledged that the home's Residents' Council were not consulted regarding the development and review of the satisfaction survey in 2016 and stated it was the home's expectation that the Residents' Council be involved in the development of the survey.

The licensee has failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

The severity of this issue was determined to be minimal harm or potential for actual harm to the resident. The scope of this issue was isolated during the course of this inspection. There have been no previous issues of non compliance related to this subsection of legislation. [s. 85. (3)]

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

Issued on this 10th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALISON FALKINGHAM (518), ADAM CANN (634), ALICIA MARLATT (590), AMIE GIBBS-WARD (630), CHRIS LAIDLAW (668)
Inspection No. / No de l'inspection :	2017_531518_0006
Log No. / Registre no:	003337-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 19, 2017
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	Berkshire Care Centre 350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bidarekere Swamy

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The home shall:
a) ensure the plan of care for a resident and all residents who use a medical device will have clear directions for the their use
b) ensure the plan of care for a resident and all residents who use a medical device sets out assessments, monitoring, documentation and clear directions for their use
c) ensure the plan of care for resident all residents who use bed rails sets out the purpose and clear directions for their use

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) This inspection was inspector initiated as a result of safety concerns observed by two Inspectors that found a resident was using two medical devices designed for safety where one of these devices were not applied properly.

A staff member told the Inspector that the resident used this medical device for safety as this resident would tend to move around in the medical device and slide down.
A staff member acknowledged the device was applied loosely and said the device was not considered a restraint as the resident could undo the device at will. In the presence
of the Inspector, the staff member asked the resident if they could undo the

device and the resident was able to undo the device.

A different staff member said they were unsure if the resident used that medical device.
The staff member reviewed the electronic chart, the plan of care and the hard copy chart in the presence of the Inspector and did not see any documentation regarding the use of the medical device for this resident. The staff member observed the resident with the Inspector and acknowledged this resident was wearing a medical device and it was loose.
The staff member asked the resident if they could undo the medical device and the resident was able to follow the instruction. The staff member told the Inspector that they therefore did not consider this to be a restraint.

The DOC and ADOC said it was the expectation that these medical devices would be included in the plan of care for residents based on an assessment of the intended purpose of the device. The ADOC said it was the expectation in the home that if a resident preferred to have the medical device applied loosely then it would be assessed and identified in the plan of care. The DOC reviewed the plan of care for the resident and acknowledged the medical device was not included as an intervention. The DOC said it was the expectation in the home that the plan of care would provide clear direction for staff regarding the use of these medical devices.
(630)

B) This inspection was inspector initiated as a result of safety concerns observed by the Inspector of a resident who was using two medical devices, one of the devices was applied very loosely with the closure resting on the resident's knees.
During another observation the resident had the medical device in place applied in an appropriate manner during an entertainment event. The resident stated they apply the medical device in the morning and remove it at night. The resident's family member stated they wanted the medical device applied daily by the staff due to the resident's memory problems and that they had told the staff of this request previously.

The clinical record review did not indicate that a medical device was used in the Minimum Data Set (MDS), no assessments were completed for the use of a medical device.
The purpose for the device's use was not included in the most recent care plan.

Two staff members stated they were unaware why the resident was using the medical device.

The DOC reported that the medical device should have been included in the plan of care and that their expectation was that medical devices were assessed, monitored, documented and included in the plan of care so clear directions are set out to the staff who provide care to the resident.
(518)

C) A resident was observed to have a bed rail raised on the left side of the bed on three separate days.
Interviews with three staff members stated that the resident used this bed rail for repositioning in bed and assisting with transferring into the standing position.
The most recent MDS stated that the resident used other types of medical devices daily. The most recent care plan did not mention the bed rails, its purpose or any assessments.

The home's policy RCS E-05 Bed Rails last revised August 10, 2013, stated:
5. Bed rail use for mobility and/or transferring, for example turning and positioning within the bed and providing a hand hold for getting into and out of bed,
should be accompanied by a care plan.
The resident should be encouraged to participate in care planning to help design a safe and comfortable environment.
The care plan should:
Include educating the resident about the bed rail danger to enable the resident to make an informed decision; and
Address options for reducing the risks of the rail use.

The ADOC and DOC stated that the plan of care did not include the use of this medical device and the expectation was that medical devices used as a PASD for bed mobility and transferring should have been included in the care plan.
(518)

D) Observations on two separate days by an Inspector found a resident had one bed rail in the raised position on the left side of the bed.

A staff member reported that they thought the resident used this bed rail to help

prevent them from falling out of bed and for positioning themselves when in bed.
A staff member told the Inspector that they were unsure which medical devices the resident used.
In the presence of the Inspector, a staff member asked a co-worker and then said that the resident used two medical devices.
The staff member said that they thought the bed rails were used to help prevent the resident from falling out of the bed.
A staff member reviewed the plan of care with the Inspector and discovered that these medical devices had not been included in the care plan.

The DOC and ADOC said it was the expectation that the plan of care would provide clear direction for staff regarding the use of the medical devices for the resident.

The severity of this issue was determined to be level two with minimal harm or potential for actual harm to the residents. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 15, 2016, as a Voluntary Plan of Correction(VPC) during the RQI 2016_276537-0012, September 23, 2015, as a VPC in a complaint inspection 2015_276537_0038, August 25, 2015, as a VPC in a complaint inspection 2015_257518_0046, and April 14, 2015 as a VPC in the Resident Quality Inspection 2015_216144_0019.
(518) [s. 6. (1) (c)]

(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will:
a) provide continuous monitoring of a resident's medical device and document the results
b) provide the use of a medical device to a resident at the scheduled times as ordered by the registered dietitian and physician

Grounds / Motifs :

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

A) During stage one of the Resident Quality Inspection a complaint was verbally received from family members that the care needed was not being provided as specified to a resident.

The resident returned to the home with two medical devices in place.

The resident has a medical device that required continuous monitoring by staff.

The resident's care plan stated the goal for the resident was to remain free of diagnosis related symptoms or complications. Outlined interventions identified the staff are to "assess, record & report to MD any symptoms which could indicate the medical device was not working properly.

A progress note completed by a registered staff member stated that when they arrived for their shift the resident was agitated and displayed facial grimacing. Upon assessment it was observed that the resident's medical device was not functioning properly. The staff member intervened appropriately and the resident

was relieved from discomfort with the medical device functioning properly.

During an interview with the Administrator, they shared that they were aware of this incident and had completed an internal investigation. They found that the responsible nurse did not appropriately assess the resident's medical condition as outlined in the plan of care. The nurse was disciplined as a result.

B) A resident's care plan stated the resident's medical device was to be operated at specific times daily.

A progress note entry made by staff stated that the resident's medical device was not initiated until a specific time. The note stated the delay in starting the device was related to staffing issues at the beginning of their shift. A progress note entry made by staff stated that the family was visiting and the medical device was being operated earlier than the scheduled time. The note stated that the medical device had been initiated at a time nine hours before the device was scheduled to start. A progress note entry stated that the homes Registered Dietitian completed an assessment of the resident and that the medical device would resume that night at the scheduled time. During an interview with a staff member they shared that they were aware of the medical device's schedule for the resident and was able to provide the correct schedule to the Inspector.

In an interview with the DON and the Administrator they shared that the care was not provided as outlined in the plan of care.

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

The severity of this issue was determined to be a level two as there was minimal risk of harm or potential for actual harm.
The scope of this issue was determined to be isolated during the course of this inspection.
The home does not have a history of non compliance in this subsection of the legislation.
(518) [s. 6. (7)]

(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 19th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alison Falkingham

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