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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 2, 2017 | 2017_606563_0011 | 016326-16, 017058-16, 029619-16, 007061-17, 007404-17, 008709-17, 008716-17 | Critical Incident System |

### 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

MELANIE NORTHEY (563), JANETM EVANS (659)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 12, 13, 14, 15 and 16, 2017**

**The following intakes were completed during the course of this inspection:**
**016326-16 - 2541-000018-16 related to staff to resident suspected abuse,**
**017058-16 - 2541-000019-16 related to resident to resident suspected abuse,**
**029619-16 - 2541-000032-16 related to resident to resident suspected abuse,**
**007061-17 - 2541-000010-17 related to a fall,**
**007404-17 - 2541-000012-17 related to resident to resident suspected abuse,**
**008709-17 - 2541-000016-17 related to staff to resident suspected abuse,**
**008716-17 - 2541-000018-17 related to staff to resident suspected abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Directors of Care, the Recreation Director, the External Behavioural Supports Ontario Registered Nurse, the Behavioural Supports Ontario Personal Support Worker, the Quality Improvement Educator, the Administrative Assistant, a Housekeeper, Registered Nurses, Registered practical Nurses, Personal Support Workers and residents.**

**The inspector(s) also made observations of residents and care provided. Relevant policies and procedures, clinical records, investigation notes and plans of care for identified residents were reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

The Critical Incident (CI) System reports #2541-000018-16, #2541-000016-17 and #2541-000018-17 documented incidents of staff to resident suspected abuse. The outcome of the investigation was not reported to the Director. There was no amendment to the CI report.

The Assistant Director of Care (ADOC) shared that the CI reports were not amended with the outcome of the investigations for both critical incidents #2541-000016-17 and #2541-000018-17. The ADOC acknowledged that CI #2541-000018-16 should have been amended with the investigation's outcome.

The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread for four of four residents during the course of this inspection. There is a compliance history of legislation s. 23 (1)(a) being issued in the home as a Voluntary Plan of Correction (VPC) during Complaint Inspection # 2016_254610_0027 on August 25, 2016. [s. 23. (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 the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.***

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**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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the fall program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and a written record relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The "Quality Management – (Long Term Care) LTC Program/Committee Evaluation Tool" for the "Fall Program" was dated February 15, 2017. The "Summary Changes Made/Accomplishments" included the implementation of a "post fall assessment tool; bed alarm, chair alarms and floor mats in place; care plans reviewed and updated; physio assessed ambulation and made changes required to logos for transfers; and program evaluated proper fitting of wheelchair and walkers for better ambulation." There were no dates when those changes were implemented. The list of "Summary Changes

Made/Accomplishments” were identical to those documented on the evaluation last year on March 3, 2016 with no dates to indicate when those changes would be made.

The Responsive Health Management 2004 "Falls Prevention Program" policy index ID: QIP 1–05–25 last reviewed January 19, 2017 stated, “The Falls Prevention program will be a evaluated annually.”

The Director of Care, and the Quality Improvement Educator (QIE) shared that an annual evaluation happened last year where the team reviewed the fall program. The QIE acknowledged that the documented procedures in place as part of the fall program and supplied by Responsive Health Management for fall documentation was not what was actually being done in the home. The DOC verified that other tools were being used. Both staff members verified that the evaluation did not have time frames documented to indicate when the changes would be made.

The fall program was not evaluated and updated at least annually in accordance with evidence-based practices. The fall program evaluation dated February 15, 2017 did not differ from the evaluation dated March 3, 2016 related to the changes made. There were no dates documented that those changes were implemented.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home as a Voluntary Plan of Correction (VPC) for r. 30(2) during Resident Quality Inspection (RQI) # 2016_276537_0012 on March 15, 2016 and as a VPC for r. 30(1) 4 and r. 30(2) during RQI # 2014_255516_0026 on July 3, 2014. [s. 30. (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 fall program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and a written record relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions.

A review of the PointClickCare (PCC) dashboard showed the resident had a Cognitive Performance Scale (CPS) which scored the resident with moderate cognitive impairment and had documented responsive behaviours towards other residents.

The resident was a moderate risk and a threat to self and others. A review of the current care plan documented interventions in place to monitor and reduce risk of resident to resident altercations. The interventions were not implemented and a resident was injured.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions.

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was isolated during the course of this inspection. There is no compliance history of this legislation being issued in the home in the past three years. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A resident with high risk behaviours had multiple altercations with multiple residents. The home's plan of care for safety included specific monitoring interventions. Documentation verified that those specific interventions were not implemented as planned.

The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's behaviours. The specific intervention was not implemented when required to minimize the risk of altercations and potentially harmful interactions between and among residents.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm . The scope of this issue was isolated during the course of this inspection. There is no compliance history of this legislation being issued in the home in the past three years. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

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

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**4. Analysis and follow-up action, including,**
**i. the immediate actions that have been taken to prevent recurrence, and**
**ii. the long-term actions planned to correct the situation and prevent recurrence.**
**O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the report to the Director included the description of the date and time of the incident.

The Critical Incident (CI) System report #2541-000018-17 documented an incident of staff to resident suspected abuse.

The Assistant Director of Care (ADOC) could not account for the documented date on the CI and verified that the date was not the date of the incident. The ADOC acknowledged that the incident related to suspected staff to resident abuse occurred 15 days prior to the date documented on the CI.

The licensee failed to ensure that the report to the Director included the description of the date and time of the incident that occurred on the CI report.

2. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

The Critical Incident (CI) System report #2541-000018-16 documented an incident of staff to resident suspected abuse. The report to the Director did not include the analysis and follow-up actions for long term actions to prevent recurrence. The report documented "pending" for this section.

The ADOC  acknowledged that the CI report stated, "pending" under the analysis and follow-up actions and did not include the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There is a compliance history of similar legislation being issued in the home as a Voluntary Plan of Correction (VPC) for r. 104 (2) during Resident Quality Inspection (RQI) # 2016_276537_0012 on March 15, 2016. [s. 104. (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 the report to the Director included the description of the date and time of the incident and that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (3) The licensee shall ensure that,**
**(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).**
**(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).**
**(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

A review of the home's Behaviour Management Program with a review date of November 25, 2013 was completed. The program documented that the quality team would review on a quarterly basis all indicators that impact on Responsive Behaviour Management.

The Director of Care (DOC) stated that they were unable to locate a program evaluation related to responsive behaviours. The DOC verified that a program evaluation was not completed for 2015, 2016 or 2017 related to responsive behaviours.

The licensee failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was isolated during the course of this inspection. There is a compliance history of similar legislation being issued in the home as a Voluntary Plan of Correction (VPC) for r. 53(4)(b) in Critical Incident inspection #2015_254610_0056 on December 15, 2015; as a VPC for r. 53(4)(b)(c) in Complaint Inspection #2014_255516_0035 on October 28, 2014 and as a VPC for r. 53(4)(c) in Complaint Inspection #2014_255516_0029 on August 21, 2014. [s. 53. (3) (b)]

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**WN #7: 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 of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident’s health condition no later than one business day after the occurrence of the incident.

The Responsive Health Management 2004 “Critical Incidents” policy index ID: RCS E-45 last revised March 31, 2017 documented that "the following critical incidents must be reported to the Director within one (1) business day after the occurrence of the incident" "an injury which results in a significant change in the resident’s health condition and results in a transfer to hospital."

Review of the Critical Incident (CI) System report #2541-000010-17 documented an incident where a resident sustained an injury and was transferred to hospital.

Progress notes stated the resident returned from acute care with a significant change in condition. Personal Support Workers verified the resident required more assistance for all care.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident. This Director of the Ministry of Health and Long Term care was informed seven days after the incident occurred.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was isolated during the course of this inspection. There is a compliance history of this legislation being issued in the home as a Written Notification (WN) during Complaint inspection # 2015_276537_0038 on September 23, 2015. [s. 107. (3) 4.]

**Issued on this 3rd day of August, 2017**

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

**Original report signed by the inspector.**