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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 4, 2014	2014_188168_0009	H-000323-14	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

WELLINGTON PARK CARE CENTRE
802 HAGER AVENUE, BURLINGTON, ON, L7S-1X2

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

LISA VINK (168), DARIA TRZOS (561), KELLY HAYES (583), LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 24, 25, 26, 27, 28, 31, and April 1, 2, and 3, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Environmental Services Manager (ESM), Programs Manager, Registered Dietitian (RD), Dietary Manager (DM), Admissions Co-Coordinator, Continuous Quality Improvement (CQI) Team Lead/Staff Educator, Resident Assessment Instrument (RAI) Coordinator, Social Services Worker, registered nursing staff, unregulated care providers including Personal Support Workers (PSW), residents and families.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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. (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 plan of care was not based on an assessment of the resident and the resident's needs and preferences.

The current plan of care for resident #4993 identified the use of a pressure relieving device, a bed mattress and the use of one quarter bed rail. Observation and interview with the registered staff and resident confirmed that there was not a pressure relieving bed mattress, nor any bed rails used, as preferred by the resident. [s. 6. (2)]

2. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #5064 sustained a fall in November 2013. Minimum Data Set (MDS) coding signed as completed February 21, 2014, identified under "accidents - none of the above", indicating that the resident did not have a fall in the past 180 days. Interview with RAI Coordinator confirmed that the assessment of February 21, 2014,

was not consistent with the progress notes of November 2013, indicating a fall, and that the MDS assessment was not accurate.
B. Resident #5151 was identified on the MDS assessment of August 23, 2013, as frequently incontinent of bladder and occasionally incontinent of bowel functioning. The next assessment was completed November 15, 2013, which indicated that the resident was continent of both bladder and bowel functioning, and that there was no change in the past 90 days. Interview with the RAI Coordinator confirmed that the resident did have a change in status in the 90 day period and that the assessment of November 2013, was not consistent with the assessment of August 2013.
C. Resident #4993 was identified to have an area of altered skin integrity prior to July 2013, which was assessed on April 1, 2014, as a stage II ulcer. The MDS Quarterly Assessments dated October 18, 2013, and January 17, 2014, noted the presence of one stage II ulcer. The assessments also identified the level of assistance at meal/snack times of at least extensive assistance of one staff to eat. Interview with the registered staff confirmed the location of the area of altered skin integrity and that this was the only area identified for the past two quarters.
i. The "Nutrition/Hydration Risk Assessment" which identified the resident was at moderate risk, was completed by the RD on October 19, 2013. This tool did not include that the resident had a "pressure ulcer stage I or II". The assessment was not consistent with the MDS assessment completed on October 18, 2013, related to skin conditions.
ii. The "Nutrition/Hydration Risk Assessment" which identified the resident was at low risk, was completed by the RD on January 20, 2014. This tool did not include that the resident had a "pressure ulcer stage I or II" nor that they "required extensive to total assistance at meals/snacks". The assessment was not consistent with the MDS assessment completed on January 17, 2014, related to skin conditions or physical functioning and structural problems.
iii. Resident Assessment Protocol's (RAP's) were completed related to the January 17, 2014, quarterly assessments. The Nutritional Status RAP identified "RD not able to find evidence of stage 2 wound in resident's chart" and did not include an assessment regarding the area of altered skin integrity. The Pressure Ulcers RAP identified that the resident had "a stage II pressure ulcer to the coccyx area", which was not the location of the wound. The protocols were not consistent with other assessments completed in the clinical record, during the same time period. [s. 6. (4) (a)]

3. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or

care set out in the plan was no longer necessary.

A. A review of the plan of care for resident #4986, last updated February 20, 2014, indicated a stage II ulcer and strategies in place to promote healing. Interview with staff, review of the RAP summary for the past three quarters (February 28, 2014, November 19, 2013, and August 30, 2013) and Pixalere documentation all indicated that the wound was healed on December 24, 2013. The plan of care was not revised when care needs, related to skin integrity, had changed.
B. The plan of care for resident #5053 indicated that they exhibited verbal aggression related to loss of independence and resistance to care. The Responsive Behaviour Risk Screening Tool dated January 12, 2014, did not identify verbal aggression nor resistance to care. Staff interviews confirmed that the resident did not demonstrate verbal aggression nor any resistive behaviour. Interview with the registered staff confirmed that the plan of care should have been revised, to reflect the change in care needs.
C. Resident #5013 was assessed to have a wound on March 21, 2014, a second assessment was completed on April 1, 2014, by the wound care nurse with the same findings. The resident's plan of care was not revised to include the area of altered skin integrity nor interventions to be implemented. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home did not ensure that all equipment was maintained in a safe condition and in a good state of repair.

A. The communication and response system in resident's #4993, #4996 and #5064 bathrooms could not be activated, when pulled. The cords were noted to be looped through multiple hooks on the wall.
B. Resident #2000 was unable to activate the call bell, on demand, in the ensuite washroom, verbalizing that the cord was too difficult to pull.
C. The call bell in the spa on one east, located beside the shower, would not activate, when pulled. The cord could not be pulled due to the way it was looped through multiple hooks on the wall.
D. The call bell in the spa on two east, located beside the tub, would not activate. When the cord was pulled lightly it detached from the wall plate, without activating an alert.
E. Interview with the ESM confirmed that the communication and response system was not functioning as designed, in the identified rooms and plans to complete an audit of all call bells. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home and all equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Not every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

Progress notes for resident #5013 and staff interview indicated that on a specified date in 2014, the resident reported being handled roughly during care by night staff and was administered a treatment without consent. The registered nurse responded to this allegation by contacting the manager on-call. The manager on-call sent an email the same day, to notify all management staff regarding the incident. Interview with the SSW and Admission Co-Coordinator confirmed that an immediate investigation did not occur for the alleged incident of abuse that was reported. [s. 23. (1) (a)]

2. Appropriate action was not taken in response to every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported to the licensee.

Progress notes for resident #5013 and staff interview indicated that on a specified day in 2014, the resident reported being handled roughly during care by night staff and was administered a treatment without consent.
The Abuse and Neglect Policy - Index I.D: RCS P-10, revised July 15, 2013, indicated: that when the home becomes "aware of suspected abuse of a resident the Administrator or DON must notify Ministry of Health immediately, inform the implicated staff about the allegation as quickly as possible, investigate the incident immediately while witnesses are readily available and the person discovering the abuse should prepare a written report of the incident, including what and when it occurred, who was involved and written statements". Interview with the SSW and Admission Co-Coordinator confirmed that the home did not take actions according to the Abuse and Neglect policy in response to the allegations and that no further documentation or follow up occurred regarding the allegations until April 2, 2014. [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated and that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care was not based on, at a minimum, an interdisciplinary assessment of the dental and oral status, including oral hygiene.

Review of resident #4986's plan of care, last updated February 20, 2014, specified that they had their own teeth and strategies in place to promote healthy oral hygiene. Interview with the staff and observation confirmed that the resident no longer had any teeth. Dietary interventions were in place to accommodate the resident's needs related to dentition. The plan of care was not based on the interdisciplinary assessment for dental and oral status. [s. 26. (3) 12.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment of the dental and oral status, including oral hygiene, 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 did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Resident #5000 was observed on March 25, 27, and 31, 2014, to have dirt and debris under their fingernails. Review of the plan of care, last updated on January 23, 2014, did not include any interventions related to nail care. Point of Care (POC) records and staff interview confirmed that staff did not document the resident's response to interventions related to nail care, which was to be completed and reassessed during bath days since July 12, 2011. According to the RAI Coordinator and nursing staff, the nail care was not triggered to be documented in POC and was only offered on an "as need basis".
B. Resident #5013 had a wound, which was identified as reopened on March 21, 2014, as identified during an interview with the registered staff. There was no documentation of the assessment conducted on March 21, 2014, in the electronic record. Interview with the wound care nurse confirmed they were notified of the wound and assessed it on April 1, 2014, however there was no record of this assessment as of April 2, 2014, in the home's wound care program, Pixalere. [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 #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee did not ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31.

A. Resident #5053 was restrained without an assessment which identified risk or alternatives to the device, prior to March 25, 2014.
i. The resident had used two one quarter rails in the raised position, one on each side of the bed, as a restraint, prior to March 2014, as confirmed during staff interview.

ii. The past two Quarterly Medication Reviews included physician's orders for two quarter rails while in bed for personal safety.
iii. The plan of care included the use of two quarter rails, prior to March 2014.
iv. An Initial Assessment for Restraints was not completed until March 25, 2014, which included resident risk and alternatives to the device. This assessment identified the Power of Attorney (POA) provided consent for the use of the rails. No other restraint assessments were available in the clinical record, with the exception of April 19, 2012, where an Interdisciplinary Restraint Assessment was initiated but incomplete.
B. The use of the restraint for resident #5053 was not documented as required, including the person who applied the device; the time of application, removal, monitoring and repositioning; and all reassessments.
i. There was no record of documentation in POC that staff were recording the person who applied the rails; the time of application, removal, monitoring or repositioning of the resident as directed in the home's policy.
ii. The reassessment of the restraint was included on the electronic Treatment Administration Record (eTAR) effective March 25, 2014. There was no evidence that prior to March 25, 2014, reassessment of the device was documented. [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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31, 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a registered dietitian (RD) who was a member of the staff of the home.

Resident #4993 had an area of altered skin integrity identified prior to July 2013, which continued and was assessed as a stage II ulcer on April 1, 2014. According to the clinical record the RD did not assess the resident related to the area of altered skin integrity. Interview with the DM and registered staff were unable to provide documentation that an assessment had been completed. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are assessed by a registered dietitian who was a member of the staff of the home., 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. Actions taken to meet the needs of the resident with responsive behaviours did not include documentation of the resident's responses to the interventions.

A. Resident #4995 demonstrated responsive behaviours during a specified day shift in 2014, which required pharmacological interventions to manage. Staff documented the initial behaviours demonstrated, interventions of staff and family notification. Documentation did not include the resident's response to the interventions in the progress notes. Interview with registered staff confirmed that follow up documentation regarding the resident's behaviour and response to interventions should have been completed on the shifts following the incident.
B. Resident #4995 was reported to demonstrate responsive behaviours, including resistance and refusal of care. It was identified on March 25, 2014, that the resident had clean long fingernails. On March 31, 2014, the resident was noted to have their nails trimmed. Interview with the PSW confirmed that the resident had recently refused bathing activities, which included nail care, however accepted the care on March 30, 2014. The PSW identified that the refusal of bathing would be documented. There was no record in the electronic file to indicate that the resident refused bathing on their scheduled bath days prior to March 25, 2014, or the interventions of staff to respond to the behaviour, which was confirmed during staff interview. [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 actions taken to meet the needs of the resident with responsive behaviours includes 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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Not every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

Resident #4994 provided a verbal compliant to staff in 2013, at which time a Client Service Response form was completed. Action was not taken within 10 days, when

documented on the Response and Resolution Report, which was confirmed during an interview with the SSW. [s. 101. (1) 1.]

2. A documented record was not kept which included, 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; or the final resolution, if any.

Client Service Response form for resident #4994's complaint detailed the concern of an odour in the bedroom. The corresponding Response and Resolution report indicated that, a call was placed to the family to implement interventions and when interventions were to be in place. Interview with the SSW identified documentation related to complaints was also completed in the clinical records. Progress notes were reviewed and no additional documentation was located regarding the complaint, related to follow -up actions taken and the final resolution. [s. 101. (2)]

3. The documented record was not reviewed and analyzed for trends at least quarterly; the results of the review and analysis were not taken into account in determining what improvements were required in the home; nor a written record kept of each review and of the improvements made in response.

A. The Compliant Investigation policy LGM I-105, last reviewed November 14, 2011, identified that at the end of each month, the SSW will complete a summary of the Client Services Response Forms and Response and Resolution Report received for that month.
i. Interview with the SSW confirmed that this summary was not currently being completed.
ii. The SSW completed a Monthly Client Service Response Tracking Tool, which showed the total number of complaints for each month. For February 2013, the tracking tool identified zero complaints however documentation identified that two complaints were investigated. An error in the tracking system was confirmed by SSW.

B. The policy stated that the monthly reports were to be reviewed by the Quality Management Team for trends to determine improvements. The Quality Improvement Lead was to provide a quarterly summary of all Client Service Responses Forms, to the team. Interview with the CQI Team Lead/Staff Educator confirmed that this process was not currently in place.
C. Interview with the Administrator confirmed that there were no written records of the compliant reviews or action taken of improvements made. [s. 101. (3)]

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 investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint; and a documented record kept in the home which includes, 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; or the final resolution, if any; and that the documented record be reviewed and analyzed for trends at least quarterly; the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program.

A. Resident #5031 was on precautions on March 24, 2014, and March 25, 2014. On March 25, 2014, not all personal protective equipment (PPE), specifically gowns were available for staff at the entrance of the room. Staff were able to locate and provide gowns when requested by the inspector.
B. On March 25, 2014, a private caregiver entered resident #5031's room without donning a gown, as required for the precautions.
C. Resident #1000 was on precautions on March 31, 2014. On March 31, 2014, between 1015 hours and 1440 hours no gowns were available for staff at the entrance of the resident's room. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Where bed rails were used, the resident was not assessed in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

The plan of care, observations and staff interviews confirmed that resident #5064 used one quarter bed rail in the raised position as a Personal Assistance Services Device (PASD) to support bed mobility. The most recent assessment for the use of bed rails in the clinical record was dated July 2013, and was for the use of one full and one quarter rail. Interview with the DON and registered staff confirmed that when bed systems were evaluated the home changed bed rails to reduce entrapment risks. The resident's bed rails were changed at that time from the full rail to quarter rails. Staff were unable to recall a bed rail assessment completed of the resident at the time of rail change. [s. 15. (1) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur did not immediately report the suspicion and the information upon which it was based to the Director.

Progress notes for resident #5013 and staff interview indicated that on a specified day in 2014, the resident reported being handled roughly during care by night staff and was administered a treatment without consent. The registered nurse responded to this allegation by contacting the manager on-call. The manager on-call sent an email the same day, to notify all management staff regarding the incident. There was no documented evidence to support that the home immediately reported the suspicion of abuse to the Director. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Not every resident received fingernail care, including the cutting of fingernails.

Resident #5000 was observed on March 25, 27, and 31, 2014, to have dirt and debris under their fingernails. The current plan of care did not include strategies or interventions related to nail care and cleaning. Staff interview indicate that nail care was completed on bath days. There was no documentation in the POC for January, February, or March 2014, to indicate that nail care was provided for the resident. [s. 35. (2)]

WN #14: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Residents' Council Minutes were reviewed for the past year. These minutes did not include the licensee seeking the advice of the Council in the development of the satisfaction survey or in acting on its results, which was confirmed during an interview with the current Programs Manager. Interview with the President of Residents' Council confirmed that the Council had not been involved in the satisfaction survey. [s. 85. (3)]

2. The licensee did not make available to the Residents' Council or the Family Council the results of the satisfaction survey in order to seek the advice of the Councils about the survey.

A. Residents' Council Meeting Minutes were reviewed for the past year and did not include the results of the satisfaction survey in order to seek the advice of Council, this was confirmed during an interview with the Council President and the Administrator.
B. Family Council Meeting Minutes were reviewed for the past year and did not include the results of the satisfaction survey in order to seek the advice of Council, this was confirmed during an interview with a representative of the Council and the Administrator. [s. 85. (4) (a)]

Issued on this 4th day of April, 2014

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

LVink

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), DARIA TRZOS (561), KELLY HAYES (583), LALEH NEWELL (147)
Inspection No. / No de l'inspection :	2014_188168_0009
Log No. / Registre no:	H-000323-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 4, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	WELLINGTON PARK CARE CENTRE 802 HAGER AVENUE, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

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. (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
(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).

Order / Ordre :

The licensee shall ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of all residents, including #5064, #5151, and #4993, so that their assessments are integrated, consistent with and complement each other.

Grounds / Motifs :

1. Previously identified as a VPC on October 16, 2013.

Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #5064 sustained a fall in November 2013. Minimum Data Set (MDS) coding signed as completed February 21, 2014, identified under "accidents - none of the above", indicating that the resident did not have a fall in the past 180 days. Interview with RAI Coordinator confirmed that the assessment of February 21, 2014, was not consistent with the progress notes of November 2013, indicating a fall, and that the MDS assessment was not accurate.
B. Resident #5151 was identified on the MDS assessment of August 23, 2013, as frequently incontinent of bladder and occasionally incontinent of bowel functioning. The next assessment was completed November 15, 2013, which

indicated that the resident was continent of both bladder and bowel functioning, and that there was no change in the past 90 days. Interview with the RAI Coordinator confirmed that the resident did have a change in status in the 90 day period and that the assessment of November 2013, was not consistent with the assessment of August 2013.
C. Resident #4993 was identified to have an area of altered skin integrity prior to July 2013, which was assessed on April 1, 2014, as a stage II ulcer. The MDS Quarterly Assessments dated October 18, 2013, and January 17, 2014, noted the presence of one stage II ulcer. The assessments also identified the level of assistance at meal/snack times of at least extensive assistance of one staff to eat. Interview with the registered staff confirmed the location of the area of altered skin integrity and that this was the only area identified for the past two quarters.
i. The "Nutrition/Hydration Risk Assessment" which identified the resident was at moderate risk, was completed by the RD on October 19, 2013. This tool did not include that the resident had a "pressure ulcer stage I or II". The assessment was not consistent with the MDS assessment completed on October 18, 2013, related to skin conditions.
ii. The "Nutrition/Hydration Risk Assessment" which identified the resident was at low risk, was completed by the RD on January 20, 2014. This tool did not include that the resident had a "pressure ulcer stage I or II" nor that they "required extensive to total assistance at meals/snacks". The assessment was not consistent with the MDS assessment completed on January 17, 2014, related to skin conditions or physical functioning and structural problems.
iii. Resident Assessment Protocol's (RAP's) were completed related to the January 17, 2014, quarterly assessments. The Nutritional Status RAP identified "RD not able to find evidence of stage 2 wound in resident's chart" and did not include an assessment regarding the area of altered skin integrity. The Pressure Ulcers RAP identified that the resident had "a stage II pressure ulcer to the coccyx area", which was not the location of the wound. The protocols were not consistent with other assessments completed in the clinical record, during the same time period. [s. 6. (4) (a)]
(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 09, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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 4th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : LVink

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

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