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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2016	2016_511586_0010	029206-16	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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST MISSISSAUGA ON L5B 1B5

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

JESSICA PALADINO (586), CATHIE ROBITAILLE (536), YVONNE WALTON (169)

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): October 4, 5, 6, 7, 11, 12, 13, 14, 17, 18 and 19, 2016.

The following Critical Incident System (CIS) Intakes were completed concurrently with the RQI:
009938-15 - Prevention of Abuse & Neglect
027061-16 - Prevention of Abuse & Neglect
017792-16 - Prevention of Abuse & Neglect

024186-16 - Prevention of Abuse & Neglect
017419-15 - Transferring & Positioning
018635-16 - Prevention of Abuse & Neglect
030566-16 - Prevention of Abuse & Neglect
032964-15 - Pain Management

The following CIS Intake was completed as an on-site inquiry:
004764-16 - Personal Support Services

The following Complaint Intakes were completed concurrently with the RQI:
002696-14 - Reporting & Complaints; Falls Prevention
009255-15 - Accommodation Services
012567-15 - Personal Support Services
022084-15 - Personal Support Services; Sufficient Staffing
027524-15 - Personal Support Services; Prevention of Abuse & Neglect
035121-15 - Skin & Wound
035338-15 - Falls Prevention
004836-16 - Reporting & Complaints; Prevention of Abuse & Neglect
017005-16 - Residents' Rights
021985-16 - Skin & Wound
023761-16 - Residents' Rights
029381-16 - Medication

The following Follow-up Intakes were completed concurrently with the RQI:
016913-15 - Nutrition & Hydration
016942-15 - Food Production

During the course of the inspection, the inspector(s) spoke with the Administrator, Medical Director, Director of Nursing, Quality Indicator (QI) Lead, Business Manager, Admissions Coordinator, Staffing Coordinator, Social Services Worker, Resident Assessment Instrument (RAI) Coordinator, registered and non registered staff, residents, and families.

During the course of the inspection, the inspectors reviewed resident health records, investigative notes, complaints logs and files, policies and procedures; toured the home; observed food production and meal service; and observed residents and care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_191107_0001	586
O.Reg 79/10 s. 72. (3)	CO #006	2015_191107_0001	586

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).

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse and neglect.

A) On an identified date in 2016, resident #005, reported that they were physically assaulted by PSW #001 and sustained a minor injury. Review of the home’s internal investigation notes confirmed that the abuse was founded and the staff member was terminated. Interview with the Administrator on October 12, 2016, confirmed that the incident occurred and that the resident was not protected from abuse.

B) On an identified date in 2015, resident #010’s spouse complained that they had alerted the staff that their family member needed their brief changed. The call bell was not answered for 45 minutes at which time PSW #002 said they could not change the resident’s soiled brief because their shift ended at 1500 hours. The home completed an internal investigation which revealed that upon interview about the incident, the staff confirmed the information. Interview with the Administrator on October 12, 2016, confirmed that the resident was left in a soiled brief for over one hour, and confirmed that resident #010 was not protected from abuse by the PSW.

C) Resident #014 requested to have a change in their attending physician. The Administrator spoke with the Medical Director and requested the attending physician to follow up on the resident's request. On an identified date in 2016, the physician spoke to the resident in a demeaning way and was angry, according to the resident. The resident identified the physician was angry. The Administrator and Medical Director confirmed that the remark by the physician was intimidating toward the resident as the physician was in a position of authority toward the resident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident is protected from abuse and neglect, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in 2015, PSW #003 was transferring resident #031 when the staff member tripped and cause injury to the resident. The home’s internal investigation revealed that the PSW confirmed they were transferring the resident by themselves; however, the resident’s transfer status at the time of the incident was two-person extensive assistance. Interview with the Administrator on October 12, 2016, confirmed that resident #031 was not transferred safely as per their plan of care. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 failed to ensure that the advice of the Residents' Council was sought out in developing, carrying out and in acting on the results of the annual satisfaction survey.

Review of the Residents' Council meeting minutes and interview with the Council's Assistant on October 7, 2016, confirmed that the Council was not given input into developing and carrying out the home's annual satisfaction survey within the last year. [s. 85. (3)]

2. The licensee failed to ensure that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

Review of the Residents' Council meeting minutes and interview with the Council's Assistant on October 7, 2016, confirmed that the results of the home's annual satisfaction survey within the last year was not shared with the Council. [s. 85. (4) (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 the advice of the Residents' Council is sought out in developing, carrying out and in acting on the results of the annual satisfaction survey, as well as to ensure the residents of the survey are made available to the Residents' Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that care was provided to resident #009 as per the plan of care.

A) Resident #009, who was not cognitively impaired, had a specific health diagnosis that required staff to approach the resident in a certain way, and this was confirmed in their documented plan of care.

During Stage 1 interview with the resident they indicated that staff do not follow the direction as indicated on their documented plan of care, even though they said they would appreciate it if the staff did so. On an identified date in October 2016, registered staff #004 entered the resident's room to provide care, and observation by the LTC Inspector, as well as interview with the resident immediately after, confirmed the interventions outlined in the plan of care were not implemented by the staff member. Interview with the Administrator on October 17, 2016, confirmed that the resident's plan of care was not followed.

B) Resident #009 was at a high nutritional risk. During Stage 1 interview with the resident they indicated that they felt the meals were often too light and that they remained hungry after meals at times. They also said that staff did not always offer seconds.

The resident's documented plan of care included a specific intervention for weight maintenance. Their meal service report, which dietary staff use when serving the resident, also indicated this. During lunch service on an identified date in October 2016, as observed by the LTC Inspector, resident #009 was given their meal without the intervention outlined in their plan of care. The Dietary Manager and Food Service Supervisor confirmed resident #009's nutritional plan of care was not followed. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that all concerns or recommendations raised by the Residents’ Council were responded to in writing within 10 days of receiving the advice by the licensee.

Review of the 2016 Residents’ Council meeting minutes identified that on the May 4, 2016, meeting, several nursing and personal care concerns and recreation and social activity concerns were brought forward by the Council. Interview with the Council’s Assistant on October 12, 2016, confirmed that a follow-up and response to the concerns could not be located. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure interventions were implemented to mitigate resident #009's nutrition care risks.

Resident #009, who was not cognitively impaired, had a specific health diagnosis that required staff to assist the resident with a particular aspect of their meals, and this was confirmed in their documented plan of care. The resident was at a high nutritional risk. During Stage 1 interview with resident #009, the resident commented on how staff did not always assist them as they required, but would find this very helpful.

During lunch observation, PSW #005 was observed serving the resident, but did not assist the resident to meet their needs during the meal. The resident's table mate, resident #035, then had to assist the resident. Interview with the Administrator on October 17, 2016, confirmed that the PSW did not support resident #009's mealtime experience and their nutritional care needs. [s. 68. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily and weekly menus were communicated to the residents.

The first option lunch menu for an identified date in October 2016, was bratwurst on a bun with garden salad and stewed strawberries and rhubarb. The menu boards posted outside of each of the three dining rooms did not have the bratwurst or salad listed, and only included stewed strawberries and half of a banana as the dessert. During lunch service, resident #010's family member was observed asking the dietary staff about what was being served, and enquired about the strawberries and banana. Interview with the Dietary Manager confirmed that the menu boards were not updated and therefore the daily menu was not communicated to the residents. [s. 73. (1) 1.]

2. The licensee failed to ensure proper feeding techniques were used to assist residents with eating.

During lunch service on an identified date in October 2016, registered staff #006 was observed feeding resident #036 soup while standing beside the resident. Upon interview with the staff member, they indicated that all chairs were occupied at the moment, though confirmed they should have been sitting while feeding the resident. After intervention by the LTC Inspector, the staff member obtained a chair to continue feeding. Resident #006 was not fed safely and in a manner that maintained their dignity. [s. 73. (1) 10.]

Issued on this 9th day of November, 2016

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

Original report signed by the inspector.