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
Nov 12, 2014	2014_188168_0026	H-001475-14	Complaint

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

ANSON PLACE CARE CENTRE
85 Main Street North, Hagersville, ON, N0A-1H0

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7, and 10, 2014.

This Inspection Report includes inspection findings for the following Complaint Inspections H-001475-14, H-001499-14 and H-001504-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staffing Clerk, Registered Nursing staff, Personal Support Workers (PSW's) and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home and reviewed relevant records including but not limited to: policies and procedures, staffing schedules, work routines and clinical records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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 O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was bathed, at a minimum, twice a week, unless contraindicated by a medical condition.

A review of Flow Sheets suggested that bathing was not consistently completed as planned/scheduled. Interviews with PSW staff identified that bathing would be documented on the Flow Sheets. The staff indicated that in a specific situation bathing activities may not be carried out and confirmed that when the task was not completed as scheduled they would document an "8" in the Flow Sheet Records for "bathing did not occur" as per the codes.

A. The plan of care identified that resident #08 was to be bathed twice a week. The bath schedule identified that the resident was to be bathed once a week only, which was confirmed by a PSW staff, due to the resident's behaviours. The Flow Sheet for August 1-31, 2014, noted that bathing was completed on four occasions only. The Flow Sheet for September 1-30, 2014, noted that bathing was completed on three occasions only. The Flow Sheet for October 1-16, 2014, noted that bathing was completed on two occasions only.
B. The plan of care and bath schedule identified that resident #05 was to be bathed twice a week. Flow Sheet for August 17-31, 2014, noted that bathing was completed on only two occasions. The Flow Sheet for October 1-16, 2014, noted that bathing was completed on only two occasions.
C. The plan of care and bath schedule identified that resident #06 was to be bathed twice a week. The Flow Sheet for August 17-31, 2014, noted that bathing was completed on one occasion only. The Flow Sheet for September 1-16, 2014, noted that bathing was completed on three occasions only. The Flow Sheet for October 17-31, 2014, noted that bathing was completed on three occasions only.
The residents were not bathed, at a minimum of, twice a week. [s. 33. (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 each resident is bathed, at a minimum, twice a week, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they immediately forwarded any written complaints, that had been received, concerning the care of a resident to the Director.

The Administrator confirmed that in 2014, she was forwarded an email from a staff member, written by a third party, concerning the care of a resident. Interview with the Administrator and DOC confirmed that the written complaint was not forwarded to the Director as required. [s. 22. (1)]

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

Specifically failed to comply with the following:

s. 101. (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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written complaint made to the licensee concerning the care of a resident had a response made to the person who made the complaint, indicating: what the licensee had done to resolve the complaint, or if the licensee believed the complaint to be unfounded, the reasons for the belief.

The Administrator confirmed that in 2014, she was forwarded an email from a staff member, written by a third party, concerning the care of a resident. The Administrator reviewed the email and forwarded it to the DOC who initiated an investigation. Interview with the Administrator and DOC confirmed that they received the complaint, however, did not provide a response to the person who made the complaint or the staff member who forwarded the complaint to their attention. [s. 101. (1) 3.]

Issued on this 12th day of November, 2014

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