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

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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
Aug 26, 2015	2015_240506_0018	H-003051-15	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

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

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

LESLEY EDWARDS (506), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), 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): August 11, 12, 13, 17, 18, 19 and 20, 2015.

The following inspections were conducted concurrently with this inspection- Complaint Inspection log numbers- H-003119-15 and H-001662-14; Critical Incident Inspections log numbers- H-002387-14 and H-003017-15 and Follow up Inspection log number H-000884-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) coordinator, Food Service Manager/Environmental Supervisor (FSM/ESM), Maintenance staff, Programs Manager, Business Manager, Nurse Consultant, Registered Dietitian (RD) registered staff, Physiotherapist, personal support workers (PSW's), housekeeping staff, dietary staff, recreation staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed residents in dining areas and care areas; reviewed policies and procedures; resident health records; the home's internal investigation notes and staff schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 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
O.Reg 79/10 s. 134.	CO #001	2014_247508_0016	506

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #100 was cared for in a manner consistent with their needs.

Resident #100's documented plan of care indicated that the resident required one person extensive assistance for toileting.

i. A progress note created by the RN on an identified date in July 2015, documented a concern brought forward by resident #100. The resident reported an incident where a staff member told the resident to use a specific method for toileting during the night, rather than their preferred method which was the resident's preference. The staff were too busy doing paperwork to toilet the resident using their preferred method; the resident indicated they were not happy with this treatment.
ii. The home's internal investigation notes confirmed the resident was not happy with this treatment.
iii. The documented interview between the Administrator and the staff member on an identified date in July, 2015, confirmed that the staff was aware of the resident's preference for toileting.
Interview with the DOC on an identified date in August 2015, confirmed that resident #100 was not cared for in a manner consistent with his or her needs. [s. 3. (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 residents are cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #2: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #101 was provided to the resident as per the plan.

Resident #101's written plan of care identified the resident to be at high nutritional risk and was to be monitored for aspiration. The resident was also to receive thickened fluids and another specified intervention for their fluids. During the afternoon nourishment pass on an identified date in August 2015, the resident was served a beverage of thin consistency, and was not given their specified intervention. The resident was not monitored while they were consuming the beverage, and was observed coughing three times while drinking the beverage. The PSW who served the resident confirmed that the resident was to receive thickened fluids. The FSM confirmed the resident's plan of care was not followed. [s. 6. (7)]

2. The licensee has failed to ensure that resident #001 was reassessed and their plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary

Resident #001's mobility plan of care indicated that the resident was dependent in a wheelchair with interventions for fall prevention. There was no mention in the resident's plan of care to be in a tilted position in their wheelchair.
i. The resident was observed in their wheelchair on an identified date in August 2015, in a tilted position, without the fall prevention strategies in place.
ii. Interview with the RN and PSW on an identified date in August 2015, confirmed that the resident no longer required the use of the fall prevention strategies, but now required being in a tilted position.
iii. The RN confirmed that the resident was not reassessed and their plan of care reviewed and revised when the resident's mobility care needs changed. [s. 6. (10) (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 the planned care for residents is provided to the resident as per the plan of care and residents are reassessed and their care plans are reviewed and revised when their is a change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with:

1. Stairway doors leading from the basement to the upper floors were not connected to the resident-staff communication and response system located on the 2nd floor. One door in the basement (near kitchen) did not continue to alarm after the door was closed. A code should have been entered onto the key pad at the door before the alarm ceased ringing.

2. Stairway doors (3 in total) leading down from the second floor were not equipped with an audible door alarm at each door.

3. The storage room in the basement and the staff lounge with kitchenette and staff change rooms which are considered "non-residential" areas were not kept locked when unsupervised by staff. The storage room was wide open for several hours on August 12, 2015 and was equipped with a lock but not kept locked. The door leading to the staff area was not equipped with a locking mechanism.

The basement area, according to the Administrator is occasionally used by residents for activities which are supervised by staff. [s. 9. (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 doors in the home are connected to the resident-staff communication response system, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents and that could be easily seen and accessed by staff, family and residents at all times. An activation station was missing in the basement auditorium, basement solarium, basement hair salon, outdoor patio and second floor dining room. The basement and outdoor patio was identified by management staff to be an area that is occasionally visited by residents and escorted by their families or a staff member. The second floor dining room was observed to be occupied by residents during the inspection.

Non-compliance was previously identified by inspectors during a resident quality inspection completed in July 2014 and the licensee was to institute a voluntary plan of compliance. During this visit, the administrator did not have a plan in place to install the activation stations and have them connected to the resident-staff communication and response system. [s. 17. (1) (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 home is equipped with a resident-staff communication and response system that is available and accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table

were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied is titled "In all other areas of the home". A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in a tub/shower room, two ward bedrooms and one adjoining washroom and several corridors on the 2nd floor. The meter was held a standard 30-36 inches above and parallel to the floor. Window coverings were drawn in the resident bedrooms tested and lights were turned on 5 minutes prior to measuring. Areas that could not be tested due to natural light infiltration were dining rooms, common areas and basement solarium. The auditorium was occupied at the time of the inspection and was not tested. Based on appearance and type of light fixtures, the solarium, auditorium and second floor lounge (near elevator) did not appear to be equipped with adequate light levels. Outdoor conditions were bright during the measuring procedure.

A) Resident Bedroom #202 and #217 were measured on August 12, 2015 and were similarly equipped with the same light fixtures as all of the other rooms, whether private, semi-private or ward. Each room had a wall mounted over bed light fixture which consisted of fluorescent tubes and a semi flush ceiling mounted light fixture at the entrance to the rooms. None of the rooms were equipped with bedroom ceiling fixtures. Over bed lights were tested and were approximately 400-450 lux and above the minimum requirement of 376.73 lux. The entrance to both bedrooms was 65-100 lux under the opaque lens of the entry light. In both bedrooms tested, the bed closest to the door was used for assessment. The lux at the foot of the bed was 50 and at the side of the bed (closest to the wardrobe) was 100 (in both rooms). The area between two beds was also 100 lux. The centre of the room was approximately 50 lux when all of the over bed lights were on (both top and bottom bulb). The minimum required lux level for the room in areas where activities of daily living take place such as sitting, dressing and walking is 215.28 lux.

B) The corridors on the 2nd floor consisted of a drop ceiling, with 2 foot by 2 foot troffer style fluorescent tube lights behind a clear lens spaced 8 feet apart. Various types of tube lights were noted (different in colour) and may have also been of different ages. Down the centre of the west corridor, (and away from corridor windows or open bedroom doors) the lux was 275-450 under various fixtures and 100-150 lux between fixtures. The minimum required level is 215.28 lux of continuous and consistent lighting down the corridors. The levels between fixtures may increase if the fluorescent tubes were all 450 lux or more.

Discussion was held with the Administrator regarding the need to verify lighting levels throughout the home to determine compliance once natural light levels diminish (after sunset) to get accurate results. [s. 18.]

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 lighting requirements are maintained, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

The plan of care for resident #005 indicated that the resident was incontinent of bladder and bowel, requiring total assistance from staff. Resident #005 was put on a toileting schedule.
i. On an identified date in August 2015, resident #005 was seated in the hallway and exhibited an odour of urine. Upon observation of the resident it was confirmed that the resident was incontinent of urine and was soiled through their clothing.
ii. Interview with the day staff confirmed that the resident's incontinence schedule was not followed as per the resident's individualized plan of care. [s. 51. (2) (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 residents individualized plan of care to promote and manage bowel and bladder continence is implemented and followed, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009's seat belt restraint was applied according to manufacturer's guidelines.

i. On an identified date in August 2015, resident #008 was noted to be wearing a front fastening seat belt that was loose fitting and not applied according to manufacturer's guidelines.
ii. Review of the resident's health record and interview with a PSW confirmed that the seat belt was a restraint and that the resident could not remove the seat belt.
iii. The seat belt observed on an identified date in August, 2015, was more than four inches from the resident's abdomen which was not in accordance with the manufacturer's guidelines. This was confirmed by the RN. [s. 110. (1) 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 restraints are applied according to manufacturer's guidelines, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

The Solarium, located in the basement area of the home and was identified as an area that residents used occasionally, did not have any of the 5 large windows restricted to 15 centimeters. The windows opened to the outdoors or the patio which was not an enclosed or secured patio. [s. 16.]

WN #9: 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 has failed to ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, (ii) height upon admission and annually thereafter.

The home did not ensure that all current resident's heights were taken annually as evidenced by review of the resident's clinical records. The Registered staff and RD confirmed annual heights are not being done on all residents in the home. [s. 68. (2) (e) (ii)]

Issued on this 27th day of August, 2015

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

Original report signed by the inspector.