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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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119 rue King Ouest 11iém étage
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 30, 2018	2018_560632_0008	004729-18	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

Orchard Terrace Care Centre
199 Glover Road STONEY CREEK ON L8E 5J2

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

YULIYA FEDOTOVA (632), CATHY FEDIASH (214), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 2018.

The following intakes (inquiries) were completed concurrently with this Resident Quality Inspection (RQI):

Log #022307-17 was related to prevention of abuse and neglect, responsive behaviour
Log #017471-17 was related to prevention of abuse and neglect, responsive

behaviour
Log #007013-17 was related to prevention of abuse and neglect
Log #009746-17 was related to prevention of abuse and neglect
Log #011433-17 was related to prevention of abuse and neglect, nutrition and hydration
Log #001352-18 was related to prevention of abuse and neglect, responsive behaviour.

The following Follow Up (FU) inspections were completed concurrently with this RQI:

Log #009083-17 was related to responsive behaviour
Log #009077-17 was related to medication
Log #009079-17 was related to falls prevention
Log #009081-17 was related to medication
Log #009082-17 was related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Practice Manager (CPM), the Program/Business Manager, Minimum Data Set (MDS) - Resident Assessment Instrument (RAI) Co-ordinator, Environmental/Dietary Manager, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), with residents and their families.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, staff education and audit records, investigation notes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 VPC(s)
1 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 #002	2017_570528_0012	508
O.Reg 79/10 s. 229. (4)	CO #005	2017_570528_0012	632
O.Reg 79/10 s. 53. (4)	CO #001	2017_570528_0012	508
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2017_570528_0012	632

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's clinical records for an identified period of time in 2017, was conducted.

A) A report identified that on identified dates in September, 2017, resident #006 did not receive their identified medication in accordance with the directions for use by the prescriber. A review of the resident's clinical records indicated that the resident had an identified diagnosis and received an identified medication daily. The home's investigation identified that the registered staff missed this medication, when administering the resident's medication; however, signed that it had been given on the identified dates.

B) Resident #031 was prescribed an identified medication, when needed, twice a day for an identified condition. On identified dates in November, 2017, the resident received an extra dose of the identified medication. According to the documentation available regarding the incidents, there was no harm to the resident; however, it was confirmed through the records in the clinical documentation and the internal investigation, conducted by the home, that the registered staff administered the extra dose.

C) On an identified date in October, 2017, the physician changed resident #030's identified medication from an order of three times a day (TID) to an as needed order (PRN) every six hours.

The internal investigation conducted by the home identified that the registered staff made a transcription error and the order had not been processed until the error was identified on an identified date in November, 2017. From an identified date in October, 2017 until an identified date in November, 2017, the resident received an identified medication regularly as prescribed in the previous order.

It was confirmed during a review of the home's clinical documentation and during interview with the DOC on an identified date in March, 2018, that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

In accordance with LTCHA 2007, the licensee was required to ensure there was an organized program of nursing and services for the home to meet the assessed needs of the residents.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have institute or otherwise put in place any protocol, the protocol was complied with.

Specifically, staff did not comply with the licensee’s identified clinical protocol, dated on an identified date in August, 2017.

Resident #013 had an identified diagnosis and was prescribed an identified medication to be administered four times daily at identified times. The physician’s orders also included identified monitoring checks to be done four times a day prior to medication administration.

A review of the home’s current clinical protocol directed staff to implement identified interventions, when the resident was showing signs and symptoms of an identified condition.

A review of the clinical records for resident #013 revealed that in October, 2017, the resident had a change in a condition. It was documented that the resident's identified medication was held and the resident was provided with interventions. The documentation indicated that the resident felt okay and was sleeping. Report was to be given to the following shift for further monitoring of the resident. Review of documentation completed after this indicated that there was no identified re-check of the resident after the interventions were given until the following morning.

Clinical records review identified that in October, 2017, the resident's monitoring was recorded. The record failed to indicate that interventions related to the identified protocol were implemented. The resident's monitoring was not repeated within the specified time period as required by the protocol. A review of the resident's clinical record indicated that the identified monitoring was completed at identified hours and that the identified level was recorded.

On an identified date in February, 2018, the resident's identified monitoring was documented. A review of the resident's clinical record indicated that the protocol had not been implemented although staff did hold the identified medication according to the electronic clinical records. Monitoring was not completed until nearly five hours after interventions were initiated.

On an identified date in March, 2018, the resident's monitoring was recorded. Staff followed the identified protocol; however, the resident left the home and the follow-up monitoring was not completed after interventions were provided.

On an identified date in March, 2018, resident's identified monitoring was recorded. Interventions were provided as per protocol; however, the resident's follow-up monitoring was not checked again until lunch time and according to the electronic clinical records, the identified medication was administered.

On an identified date in March, 2018, the resident's identified monitoring was recorded. The resident's clinical record indicated that the identified medication was held; however, there was no further documentation to verify if staff implemented the identified protocol and no re-check was done until their next scheduled time.

Documentation and the DOC confirmed during an interview on an identified date in March, 2018, that staff failed to ensure that the identified protocol was complied with.

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 and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to
have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that any actions taken with respect to a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in November, 2017, resident #001 had unwitnessed fall with no injury. Interview with the Clinical Practice Manager (CPM) in March, 2018, identified that substitute decision maker (SDM) notifications were to be recorded in the clinical documentation used for falls. Review of the clinical documentation records contained no information in Agencies/People Notified section that SDM of the resident was notified. Progress notes review (dated November, 2017) indicated that day staff would notify SDM in the morning. Review of the progress notes from November, 2017, contained no information about notification of SDM of the fall that had occurred in November, 2017. In March, 2018 CPM indicated that there was no information in the records to confirm that the SDM had been notified of the November 2017 fall, which was acknowledged by the DOC.

The home did not ensure that actions taken with respect to the Falls Prevention program were documented.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

The licensee failed to ensure that all menu substitutions were communicated to residents and staff.

On an identified date in March, 2018, during lunch meal observations in an identified home area, pepperoni pizza was provided to the residents. Review of the home’s week 3 Summer/Winter menu (dated in November, 2017), posted in the home, included that vegetable pizza was to be served. On an identified date in March, 2018, staff #104 stated that no vegetable pizza was available and pepperoni pizza was provided to the residents. During interview with the Environmental/Dietary Manager on an identified date in March, 2018, it was stated that pepperoni pizza was a substitute meal choice for lunch on the identified date in March, 2018, and it should have been communicated to the residents. On an identified date in March, 2018, the Administrator acknowledged that the substitution in the form of pepperoni pizza was served for lunch and this change was not communicated to the residents.

The home did not ensure that all menu substitutions were communicated to the residents and staff.

Issued on this 13th day of June, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8	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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YULIYA FEDOTOVA (632), CATHY FEDIASH (214), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2018_560632_0008
Log No. / No de registre :	004729-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 30, 2018
Licensee / Titulaire de permis :	Rykka Care Centres LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	Orchard Terrace Care Centre 199 Glover Road, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Sheppard

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_570528_0012, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131(2).

Specifically the licensee must:
a) Ensure that resident #006, #030 and #031 and all other residents are administered medications in accordance with the directions for use specified by the prescriber.
b) Ensure that all registered staff, including agency staff, are following the College of Nurses of Ontario (CNO) Standards for medication practices, when administering medications to all residents.
c) Implement an auditing system with scheduled dates to conduct audits on resident #006, #030 and #031 and other residents receiving medications to ensure that physician's orders are being accurately transcribed and medications are administered as specified by the prescriber.
d) Where errors are identified, the errors will be documented, reviewed and analyzed and actions taken as necessary. Records will be maintained of audits completed and actions taken as a result.

Grounds / Motifs :

1. The licensee failed to comply with the following compliance order #004 from inspection #2017_570528_0012 served on May 2, 2017, with a compliance date of August 2, 2017.

The licensee was ordered to ensure that all registered staff:
i. follow the College of Nurses of Ontario (CNO) Standards for medication practices when administering medications to residents;

ii. are re-trained on specific policies related to medication transcription and administration.

The licensee completed step ii.

The licensee failed to complete step i.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's clinical records for an identified period of time in 2017, was conducted.

A) A report identified that on identified dates in September, 2017, resident #006 did not receive their identified medication in accordance with the directions for use by the prescriber. A review of the resident's clinical records indicated that the resident had an identified diagnosis and received an identified medication daily. The home's investigation identified that the registered staff missed this medication, when administering the resident's medication; however, signed that it had been given on the identified dates.

B) Resident #031 was prescribed an identified medication, when needed, twice a day for an identified condition. On identified dates in November, 2017, the resident received an extra dose of the identified medication. According to the documentation available regarding the incidents, there was no harm to the resident; however, it was confirmed through the records in the clinical documentation and the internal investigation, conducted by the home, that the registered staff administered the extra dose.

C) On an identified date in October, 2017, the physician changed resident #030's identified medication from an order of three times a day (TID) to an as needed order (PRN) every six hours.

The internal investigation conducted by the home identified that the registered staff made a transcription error and the order had not been processed until the error was identified on an identified date in November, 2017. From an identified date in October, 2017 until an identified date in November, 2017, the resident received an identified medication regularly as prescribed in the previous order.

It was confirmed during a review of the home's clinical documentation and during interview with the DOC on an identified date in March, 2018, that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level (2) as there was minimal harm or potential for actual harm to the residents. The scope of this issue was a level (3) as it related to widespread non-compliance with drugs administration. The home had a level (5) compliance history as they had multiple non-compliances, non-compliance (NC) continues with original area of NC with this section of O. Reg. 79/10, s. 131(2):
- CO #004 issued May 2, 2017, with a compliance due date of August 2, 2017, (2017_570528_0012). (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 30th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Yuliya Fedotova

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