Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2020	2020_704682_0005	002356-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

AILEEN GRABA (682)

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): March 4, 5, 6, 10, 2020.

The following Complaint inspection was completed:
002356-20 related to skin and wound management, housekeeping, plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) coordinator, Registered nursing staff, Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, complaints log/ binder, staffing schedules, policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Personal Support Services
Skin and Wound Care

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

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	Légende 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was submitted to the Director.

A clinical record review identified resident #001 had a health condition. A review of resident's #001 physician orders indicated that on an identified date there was an intervention ordered. A review of the electronic treatment record (ETAR) included a task for the specific intervention. The intervention was not documented on identified dates.

During an interview, the Director of Care (DOC) confirmed that the intervention was not completed and not documented as ordered. The DOC confirmed that resident's #001 plan of care related to the intervention was not provided to resident #001 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that different approaches were considered in the review and revision of the plan of care for resident #001 when the care set out in the plan was not effective.

A complaint was submitted to the Director.

A review of resident's #001 care plan identified a focus: assistance with activities of daily living (ADL). The care plan also identified resident #001 had responsive behaviours and interventions to minimize the responsive behaviours.

A review of the Point of Care (POC), Documentation Survey Report identified resident #001 had an intervention and that resident #001 exhibited responsive behaviour for identified dates.

During an interview staff #104 stated that they would report when resident #001 exhibited responsive behaviour. During an interview, staff #107 stated that they would report and await direction from registered staff when a resident exhibited responsive behaviour. During an interview, staff #108 stated that resident #001 had responsive behaviour and that they would implement interventions. Staff #108 also stated that they would discuss further with the Director of Care (DOC) to develop additional strategies if the resident continued to exhibit responsive behaviour. During an interview, the DOC stated that different approaches were not considered to the ongoing responsive behaviour and resident's #001 plan of care was not reviewed and revised when the care was ineffective. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan; to ensure that different approaches are considered in the review and revision of the plan of care when the care set out in the plan is not effective, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint was submitted to the Director.

A clinical record review included the care plan that indicated resident #001 was to have foot care.

A review of the POC documentation indicated that resident #001 "sees the foot care nurse" (FC) on identified dates. A review of the progress notes did not include any documentation that resident #001 was assessed or provided service by the foot care nurse. Further review of the POC, Documentation Survey Report indicated that on identified dates, documentation was absent related to resident's #001 toenails being checked cleaned or trimmed by staff.

During an interview staff #105 and staff #107, both stated they documented that the foot care nurse was involved in resident's #001 care and that they did not provide toe nail trim/care when they were assigned to resident's #001 shower/bath. During an interview, the DOC confirmed that the foot care nurse did not provide care and resident #001 was not seen by a foot care nurse.

The home did not ensure that resident #001 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (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 of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A complaint was submitted to the Director.

A review of the licensee policy Client Service Response Form, INDEX I.D. LGM I-10, reviewed June 1, 2018, stated the following:
3. "Any person receiving the complaint is to document the complaint on a Client Service Response (CSR) form."
4. "The department head/ designate to provide a response to the complainant within 10 business days of the receipt of the complaint, complaints that cannot be investigated and resolved within 10 business days the Department head/designate is to provide an acknowledgement of receipt of the complaint and include the date by which the complainant can reasonably expect a resolution."

A) A clinical record review included a progress note that indicated resident's #001 substitute decision maker (SDM) had voiced concerns. Staff #109 had documented that they relayed this information to management. Further review of the progress notes did not include any additional documentation or follow up by the Environmental Service Manager (ESM) related to the SDM concerns. A review of the complaints/ log binder also did not include a CSR form related to the SDM concerns, or any actions/resolution or responses made by the complainant.

During an interview, the Administrator confirmed that a CSR form was not completed related to the SDM concerns on an identified date. During an interview, the ESM #103 denied being made aware of issues and was not involved in any resolution at the time of the incident.

The home failed to ensure that a documented record that comprised the CSR form was kept and contained the nature of the verbal complaint, the type of action taken to resolve the complaint, any follow up action and any responses made by the complainant.

B) A clinical record review included a progress note, that indicated resident's #001 SDM had concerns related to the care being provided. The Director of Care was not able to contact the SDM. A review of the complaints/ log binder also did not include a CSR form related to the SDM concerns and actions taken to resolve the concerns.

During an interview, the Administrator confirmed that a CSR form was not completed. During an interview, the DOC confirmed they did not resolve the concerns related resident's #001 care as they were not able to contact the SDM. The DOC confirmed that they did not maintain a documented record that comprised the CSR form that contained the nature of the verbal complaint, the type of action taken to resolve the complaint or any follow up action related to the complaint. [s. 101. (2)]

Issued on this 16th day of March, 2020

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

Original report signed by the inspector.