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

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

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Inspection de sions 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
Apr 21, 2016	2016_276537_0012	002275-16	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

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

NANCY SINCLAIR (537), ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144)

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): March 15, 16, 17, 18, 21, 22, 23, 24, 30, 31 and April 1, 2016.

The following Critical Incidents were inspected concurrently:

Log #033310-15/CIS 2541-000045-15 regarding alleged resident to resident abuse.
Log #030779-15/CIS 2541-000043-15 regarding alleged resident to resident abuse.

Log #029196-15/CIS 2541-000039-15 regarding alleged resident to resident abuse.
Log #012073-15/CIS 2541-000016-15 regarding alleged resident to resident abuse.
Log #000505-14/CIS 2541-000035-14 regarding alleged resident to resident abuse.
Log #000970-16/CIS 2541-000001-16 regarding alleged resident to resident abuse.
Log #033276-15/CIS 2541-000044-15 regarding alleged resident to resident abuse.
Log #003913-16/CIS 2541-000004-16 regarding alleged resident to resident abuse.
Log #000166-16/CIS 2541-000011-16 regarding alleged resident to resident abuse.
Log #035067-15/CIS 2541-000012-16 regarding alleged resident to resident abuse.
Log #033312-15/CIS 2541-000046-14;2541-000028-15;2541-000042-15;2541-000003-16;2541-000048-15 regarding alleged resident to resident abuse.
Log #034084-15/CIS 2541-000047-15;2541-000049-15;2541-000035-15 regarding alleged resident to resident abuse.
Log #034807-15/CIS 2541-000050-15 regarding alleged staff to resident abuse.
Log #007957-16/CIS 2541-000002-16 regarding injury resulting in transfer to hospital.

During the course of the inspection, the inspector(s) spoke with Residents and Families, the Administrator, Director of Care(DOC), two Assistant Directors of Care (ADOC), Maintenance Service Manager, Food Service Supervisor(FSS), Registered Dietitian, one Enterostomal Therapist(ET), one Environmental Aide, one Dietary Aide, three Registered Nurses(RN), seven Registered Practical Nurses(RPN), RAI Coordinator, nine Personal Support Workers(PSW) and one Physiotherapy Assistant(PTA).

During the course of the inspection, the inspector(s) also conducted a tour of resident and common areas, observed meal service, a medication pass, medication storage areas, recreational activities and care provided to residents, reviewed health records and plan of care for identified residents, reviewed assessments, policies, procedures, and related training records, and observed general maintenance, cleaning and condition of the home.

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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **6 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

An identified resident was observed sitting in a mobility aid.

Review of the resident's clinical record did not include the reason for the use of the mobility aid.

A Personal Support Worker(PSW) advised that the resident used the mobility aid for positioning and that the use of the mobility aid had not been monitored by nursing personnel.

A Registered Practical Nurse(RPN) confirmed that the resident should not have been placed in the mobility aid, there was not a consent from the Substitute Decision Maker (SDM) and an alternatives to use assessment of the mobility aid had not been completed.

The Director of Care(DOC) concurred that the resident's plan of care did not provide clear direction to staff regarding the use of the mobility aid for this resident. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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 :

1. The licensee has failed to ensure that any plan, policy, protocol, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy regarding recording of food and fluids consumed #FNSCN145 indicated that staff would document the percentage of each meal consumed and the amount of beverages consumed for each resident on a daily basis. The paper format would be used.
"Food and fluid intake must be recorded immediately following consumption of meals and nourishments. PSW's will document on food and fluid sheets kept in the dining room."

An identified resident had specific nutritional interventions based on assessed needs.

Interviews with the Registered Dietitian, an RPN and two PSW's revealed that it was the responsibility of the PSW to document the use of the specific nutritional interventions every shift.

Review of the resident Daily Food and Fluid Intake revealed missing documentation on 16 days.

A second identified resident also had specific nutritional interventions based on assessed needs.

Interviews with the Registered Dietitian, an RPN and two PSW's revealed that it was the PSW's responsibility to document the use of the specific nutritional interventions every shift.

Review of the residents' food and fluid documentation revealed missing documentation on six days:

The Administrator confirmed the expectation was that the homes policy regarding recording food and fluids consumed be complied with.

B) The homes policy titled "Servery/Production Temperature Audit" included the following standard:
"Food temperatures are taken prior to meals being served to ensure that food temperatures are within established standards."

During dining room observation of the lunch meal of an identified resident home area, the food temperature audit records from March 1, 2016 to March 15, 2016, were reviewed with the following results:
- breakfast food temperatures were not recorded on March 1, 2, 3, 4, 5, 6, 7, 8, 2016
- lunch food temperatures were not recorded on March 2, 4, 6, 8, 2016
- evening meal food temperatures were not recorded on March 2, 3, 4, 6, 7, 8, 9, 11, 12, 14, 2016.

A Dietary Aide confirmed that food temperatures were to be completed and recorded on the food temperature audit for each meal and that this was not done on the dates identified.

The Food Service Supervisor(FSS) confirmed that food temperatures were to be completed and recorded for each meal, the temperatures were not done and recorded on the dates identified and that the home's food temperature policy was not followed. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, strategy or system instituted or otherwise put in place 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 :

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

An identified resident required specific staff assistance for personal care.

Interviews with two RPN's and two PSW's confirmed the staff assistance for personal care required by the resident and that it was the PSW's responsibility to document this care on the resident's daily flow sheet.

Review of the residents' daily flow sheet revealed missing documentation on five days.

The homes policy titled "Assessment/Documentation Daily Flow Sheet RCS C-50", indicated that the daily flow sheet was to be completed in ink, documented observations made and care provided according to the individual resident care plan. Oral hygiene required by staff was to be documented that the care was provided or refused and if staff or resident completed the care.

The DOC confirmed the expectation was that all actions taken with respect to a resident under a program including assessments, reassessments, interventions and the residents responses to interventions were documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device(PASD) to assist a resident with a routine activity of living included alternatives to the use of the PASD, that the use of the PASD was reasonable, that an appropriate person had approved the use of the PASD and that the use of the PASD was consented to by the resident or SDM.

An identified resident was observed sitting in a mobility aid.

The legend record in the monitoring binder identified that the resident used the mobility aid. The legend record did not clearly identify who had approved the use of the mobility aid

Review of the clinical record for this resident did not include the reason for the use of the mobility aid.

Interview of a Personal Support Worker advised the reason the resident used the mobility aid. The PSW also showed the Inspector the legend record in the monitoring binder where it was identified how the resident used the mobility aid. The PSW confirmed the resident's use of the mobility aid had not been monitored by nursing personnel.

Interview with a Registered Practical Nurse(RPN) confirmed that the resident should not have been using the mobility aid, there was not a consent from the Substitute Decision Maker(SDM) and an alternatives to use assessment had not been completed.

Clinical record review revealed an assessment had been completed and documented in Point Click Care after the inspector completed interviews, that included the required assessments, documentation and consents for use. [s. 33. (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 that the use of a PASD to assist a resident with a routine activity of living includes alternatives to the use of the PASD, that the use of the PASD is reasonable, that an appropriate person has approved the use of the PASD and that the use of the PASD is consented to by the resident or SDM., to be implemented voluntarily.

WN #5: 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 nutrition care and hydration program included heights of residents to be completed upon admission and annually thereafter was complied with.

Census review for nine identified residents, during Stage 1 of the RQI, revealed that the heights were outdated and were not being completed on an annual basis.

The RAI Coordinator confirmed the identified resident heights had not been completed as required and ensured the residents heights would be taken. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration program included heights of residents completed upon admission and annually thereafter, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Three alleged, suspected or witnessed incidents of which the licensee was aware were not reported to the Director within 10 days.

The Director of Care confirmed the expectation was that all critical incident submissions included all of the required information as noted in the regulations when alleged abuse was reported and were to be completed and submitted within 10 days of becoming aware of the incident [s. 104. (2)]

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 report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, to be implemented voluntarily.

Issued on this 22nd day of April, 2016

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

Original report signed by the inspector.