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 prévue 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

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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
Oct 3, 2018	2018_532590_0017	005388-18	Resident Quality Inspection

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

Berkshire Care Centre
350 Dougall Avenue WINDSOR ON N9A 4P4

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

ALICIA MARLATT (590), CAROLEE MILLINER (144), CASSANDRA TAYLOR (725), HELENE DESABRAIS (615)

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): August 27, 28, 30, 31 and September 4, 5, 6, 7, 2018.

The following intakes were inspected concurrently:

Complaint inspection: Log #001754-18/IL-55128-LO was related to housekeeping concerns and prevention of abuse and neglect;
Complaint inspection: Log #001607-18/IL-55095-LO was related to prevention of

abuse and neglect;
Complaint inspection: Log #027116-17/IL-54289-LO was related to prevention of abuse and neglect;
Complaint inspection: Log #020080-17/IL-52525-LO and IL-56067-LO was related to prevention of abuse and neglect;
Complaint inspection: Log #009705-18/IL-56913-LO was related to prevention of abuse and neglect;
Complaint inspection: Log #018041-18/IL-58156-LO was related to prevention of abuse and neglect;
Complaint inspection: Log #021070-18/IL-58994-LO was related to prevention of abuse and neglect;
Critical Incident System (CIS) inspection: Log #021416-17/CIS #2541-000036-17 was related to responsive behaviours;
CIS inspection: Log #014020-18/CIS #2541-000037-18 was related to falls prevention and management;
CIS inspection: Log #017391-18/CIS #2541-000041-18 was related to falls prevention and management;
CIS inspection: Log #016958-18/CIS #2541-000040-18 was related to prevention of abuse and neglect;
CIS inspection: Log #024183-18/IL-59525-AH was related to prevention of abuse and neglect;
CIS Inquiry: Log #029291-17/CIS #2541-000050-17 was related to was related to prevention of abuse and neglect;
Complaint Inquiry: Log #023309-17/IL-53341-LO was related to resident rights;
Complaint Inquiry: Log #022653-17/IL-53111-LO was related to housekeeping concerns and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Wellness, the Assistant Director of Care, two Environmental Services providers, the Environmental Services Supervisor, one Physiotherapist, two Registered Nurses, 11 Registered Practical Nurses, 19 Personal Support Workers, two Health Care Aids, the representative from the Residents' Council, eight family members and 10 residents.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Infoline reports, Critical Incident System reports, Residents' Council meeting minutes, medication management processes and relevant policies and procedures related to inspection topics.

During the course of the inspection, the inspector(s) observed recreational activities, snack and dining services, infection prevention and control practices, the provision of resident care, staff and resident interactions, medication administration practices, medication storage areas, all resident home areas, the general maintenance and cleanliness of the home and the posting of required information.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 VPC(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) from the Substitute Decision Maker (SDM) of resident #016, related to the number of infections this resident had since their admission to the long term care home in early 2017.

In an interview with Director of Nursing and Wellness #105, they shared that resident #016 was on antibiotics several times for recurring infections. The Director of Nursing and Wellness said that when a resident was on antibiotics, the registered staff were expected to complete and record vital signs in Point Click Care (PCC) every shift as part of the home's process for monitoring infections.

Review of resident #016's clinical record showed that the resident was on antibiotics five different times for infections. The resident's latest care plan directed staff to monitor and document the resident's temperature in PCC every shift during antibiotic therapy. The documentation showed that there were times the resident was on antibiotics and was not monitored according to the home's processes.

In total, the resident was on antibiotics for 50 days, which would require a total of 150 documented entries into PCC or the vital sign section for eight hour shifts. Review of the progress notes and vital sign section for the identified times resident #016 was on antibiotics, showed that there were 33 percent or 50 missing documented entries.

In an interview with RPN #120 they said that when a resident was on antibiotics vitals signs should be done every shift and documented in a progress note with a heading of infection and this was to be done until the antibiotics were completed.

In an interview with RPN #104, they said that vital signs should be completed every shift and documented in PCC, along with an infection progress note. The RPN said this monitoring should be continued until the antibiotics were completed.

In an interview with Assistant Director Of Care (ADOC) #142, they said that when residents' were on antibiotics, staff should be completing and documenting vital signs in PCC, along with a general assessment of how the resident was doing. [s. 229. (5) (a)]

2. Resident #022 was admitted to the home in an identified month.

The clinical record for resident #022 stated that in the early afternoon on the second day in the home, the resident's temperature was 38.3 Celsius (C).

The clinical record did not include the provision of a treatment for the resident's elevated temperature.

The resident's temperature was recorded again in the early morning hours on the third day in the home as being 36.2 C.

On another day, resident #022's temperature was recorded as 38 C and an antibiotic was initiated for suspicion of an infection.

The Power of Attorney (POA) for resident #022 shared with the inspector during a telephone conversation, that resident #022 attended their personal physician's office five days after leaving the home and was diagnosed with an infection.

Director of Nursing and Wellness #105 told the inspector that resident #022 should have been administered medication and or an alternate treatment for their elevated temperature. Director of Nursing and Wellness #105 further said that resident #022's temperature should have been monitored a second time on the day shift on the second day, and that depending on that result, possibly monitored into the evening shift of the same date.

The Director of Nursing and Wellness agreed that resident #022 did not receive care that was consistent with their needs.

The licensee had failed to ensure that staff monitored symptoms of infection in resident's #016 and #022 on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (5) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received by the MOHLTC about the staff administering a narcotic medication without consent to a cognitively impaired resident.

In a pre-inspection interview with resident #016's Substitute Decision Maker (SDM) they shared a concern that the nursing staff had given their loved one a narcotic without them knowing. The SDM shared that their loved one has had problems in the past with being too sedated from narcotics.

Review of resident #016's physician's orders written over a specific three month time period in 2017, showed that orders for narcotics and antibiotics were initiated without consent being documented as obtained.

On a specific day in 2017, the resident was ordered an antibiotic. The area to document that consent was obtained from resident #016's SDM was empty.
On a specific day in 2017, the resident was ordered a narcotic. The area to document that consent was obtained from resident #016's SDM was empty.
On a specific day in 2017, the resident was ordered another antibiotic. The area to document that consent was obtained from resident #016's SDM was empty.
On a specific day in 2017, the narcotic dosage and frequency of administration was increased. The area to document that consent was obtained from resident #016's SDM was empty. The Administrator was able to provide a progress note documenting that the SDM wanted the analgesics increased on a specified day.

In an interview with RPN #120 they shared that consent should be obtained from the resident or their SDM prior to the initiation of new medications or changed medications and documented on the physician's order sheets when transcribed.

In an interview with Administrator #100, they shared that the home's process when transcribing physician's orders was that when an order for a medication was left, the staff should be obtaining consent from the resident's SDM if applicable prior to starting the medications and documenting it on the physician's order sheets in the consent obtained box. The Administrator was able to provide some progress note documentation related to resident #016's SDM being notified of the initiation of narcotics and antibiotics, however said that the consent was not documented as it should have been on the physician's order sheets.

The licensee had failed to ensure that resident #016's SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

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 resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On August 28, 2018, during a stage one interview with resident #009 it was reported by the resident that there had been an incident of verbal abuse from staff. The resident refused to give a staff name, date or account of the incident and expressed concerns regarding difference in treatment.

On August 28, 2018, immediately after the interview Inspector #725 informed Director of Nursing and Wellness #105 of the information provided from resident #009. Director of Nursing and Wellness stated they would investigate the concern. Inspector #590 reviewed the concern again at the end of day meeting with Administrator #100.

Review of the incident showed the home attempted to speak with the resident in a private location on August 28, 2018, at which time the resident refused. The home did not speak with the resident until August 29, 2018, at which time the action line was phoned and report number was given.

On August 31, 2018, during an interview with Director of Nursing and Wellness #105, they were asked why the home did not report the incident immediately. Director of Nursing and Wellness #105 stated they did not have enough information regarding the incident to make the report. Inspector #725 asked if the home was able to amend a Critical Incident System (CIS) report once it was initiated. Director of Nursing and Wellness #105 confirmed the home was able to amend a CIS report.

The licensee had failed to immediately report alleged abuse to the Director for resident #009. [s. 24. (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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

A complaint was submitted to the Ministry of Health and Long-Term Care from resident #016's Substitute Decision Maker (SDM) related to concerns about oral care lacking in the home.

In an interview with Director of Nursing and Wellness #105 they shared that when residents' required staff to perform their oral care, the care plan should describe the solution to be used, the frequency of cleaning required and the method to complete the cleaning, for example if a toothbrush or oral swab was used.

Resident #016's care plan documented that the resident needed daily cleaning of teeth or dentures to be completed by staff, however did not document the frequency of cleaning required, the solution to use or the method in which cleaning will be completed.

Review of resident #016's progress notes showed that the resident was treated for oral infections on two separate occasions.

Review of oral care records for resident #016 over a 13 day time period in a specific month in 2017, showed that oral care was provided only once on four of those days. Review of the oral care records over a nine day time period in another specific month in 2018, showed that oral care was provided only once on four of those days.

In an interview with ADOC #142 and Administrator #100, they shared that the care plan did not provide clear direction to staff as to when and how frequently to provide oral care to resident #016. [s. 34. (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 that residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) identifying concerns related to pain management.

In a pre-inspection interview with resident #016's Substitute Decision Maker (SDM), they shared that in January this year their loved one started yelling and calling out. The SDM shared that they felt the resident was in pain due to infections and that was the reason for them calling out. The SDM said that the home's response did not adequately assess pain issues.

Review of resident #016's care plan showed that potential for pain was identified related to their diagnosis and outlined goals that the resident would maintain an acceptable level of comfort and remain free of complications. The care plan directed staff to reassess the resident after administering pain medications, to notify the physician of pain unrelieved

by currently ordered interventions and to assess and document pain concerns using a standardized pain scale in order to evaluate severity and response to interventions.

Resident #016's electronic Medication Administration Record's (eMAR) for January and February 2018 was reviewed and it documented the resident's pain level at the time of administration of analgesics.
In January 2018 the resident's pain levels were recorded with their regularly scheduled analgesics and documented a pain level of four once, a pain level of five once and a pain level of seven once, and was otherwise documented as pain free. The resident received as needed analgesics 28 times this month with recorded pain levels of four once, a pain level of five once, a pain level of six twice, a pain level of seven three times, a pain level of eight six times and a pain level of 10 on 14 occasions.
In February 2018 the resident's pain levels were recorded with their regularly scheduled analgesics and documented a pain level of one once, a pain level of two once, a pain level of five once, a pain level of seven once and a pain level of 10 once. The resident received as needed analgesics 31 times this month with recorded pain levels of 0 once, a pain level of three once, a pain level of four twice, a pain level of five four times, a pain level of six once, a pain level of seven four times, a pain level of eight four times, a pain level of nine once and a pain level of 10 on 13 occasions.

Review of resident #016's progress notes showed a note documented by the physician on a specific day in February 2018, stating that the resident was agitated, was already on analgesics as needed, and was still yelling and screaming. A Behavioural Support Ontario (BSO) assessment was ordered at that time.
A progress note documented by the BSO team the next day, stated that the resident was displaying verbally and physically responsive behaviours. The note further documented that the resident was on analgesics twice daily and as needed and that sleeping medication had been changed in January and February. The BSO team directed staff to monitor for signs of pain and infection in the note. The progress notes further documented that resident #016 was transferred rooms on a specific day in 2018.

Review of resident #016's pain assessments for 2018 showed that one comprehensive pain assessment was completed this year on a specific day in February 2018 and it documented that the resident had satisfactory pain management at the time of the assessment.

The homes policy titled Pain Management, policy index I.D: RCS G-60, and last revised on May 29, 2018, documented that clinical pathways should be completed for acute pain,

uncontrolled pain, new onset of pain, significant change in health status, change in analgesics order and persistent/controlled pain with analgesics use. The policy further documented that a pain evaluation summary should be completed monthly if the resident was receiving any analgesia: scheduled and/or PRN, was re-admitted to the home, had a new onset of pain, had a new analgesia order, change in analgesics dosage and a change in health status.

In an interview with the ADOC and Administrator, the inspector shared the findings of the pain assessments, eMAR's and medication administration patterns with associated pain levels with them and they agreed with the inspector that this resident's pain was not reassessed appropriately. They also shared that their pain program has been updated and that they have identified the gap in pain assessments not being completed after analgesics were started.

The licensee had failed to ensure that when resident #016's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs were stored in an area or a medication cart,
i. that is used exclusively for drugs and drug-related supplies,
ii. that is secure and locked,
iii. that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
iv. that complies with manufacturer's instructions for the storage of the drugs.

Resident #008 was admitted to the home on a specific day in 2017.

During stage one of the RQI on August 28, 2018, at 0940 hours, a medication was observed on the bedside table belonging to resident #008.

The prescription label on the medication identified the medication pharmacy service provider as Family Health Pharmacy, the prescription number and that the medication was prescribed for resident #008 on a specific day back in 2016.

RPN #104 advised the inspector that resident #008 had not been prescribed the medication since admission to the home, that the home's pharmacy service provider was not Family Health Pharmacy and that resident #008 did not have a physician's order to keep medications at their bedside.

Review of the clinical record for resident #008 confirmed the resident had not been prescribed this medication since admission to the home in 2017, and that the resident did not have a physician's order to keep medications at their bedside.

Director of Nursing and Wellness #105 advised that the home's external pharmacy service provider was not Family Health Pharmacy, that the medication should not have been located at the resident's bedside and that the medication should have been seen and removed by staff.

Administrator #100 confirmed that Classic Care Pharmacy had provided pharmacy services to the home since 2013. [s. 129. (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 that drugs were stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, that is secure and locked, that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #7: 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 had failed to ensure that where the Act or the Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s. 135(1)(b) states that every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of three months of the home's medication incidents and analysis (April, May and June 2018) documented that six medication errors occurred.

A review of the home's Medication Incident Report & Analysis documented on a specific day, indicated that resident #017, did not receive their medication as prescribed and it was reported to the Director of Nursing and Wellness only. The five other incidents where medication errors occurred, were not reported to the appropriate persons as per O. Reg. 135 (1) (b).

A review of the home's policy #RCS F-45 "Medication Incident" last reviewed June 8, 2018, stated in part "Procedure: 1. All medication incidents, including near misses or close calls that are identified are to be reported immediately to the nurse or designate and to the Director of Nursing." The home's policy did not include reporting to the resident/SDM, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During an interview, Administrator #100 and Director of Nursing and Wellness #105 stated that they would expect the home's policy would be in accordance with all applicable requirements under the Act.

The licensee had failed to ensure that the home's medication incident policy was in compliance with the Act. [s. 8. (1) (a)]

WN #8: 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 :

1. The licensee had 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 last three months of medication incidents and analysis (April, May and June 2018) indicated that on three consecutive days in an identified month in 2018, resident #017 had not received their medication as prescribed.

A review of the home's policy #RCS F-64 "Transcribing physician's orders or RN (EC)'s orders" last revised July 15, 2013, stated in part "Procedure: Verify that the physician or RN (EC) order is complete, or follow up with the physician of RN (EC) to obtain a complete order to include: correct resident, name of the medication ordered whether the generic or trade name, dose of medication, route, time that the medication will be given".

Review of the home's Medication Incident Report & Analysis specifically dated in 2018, revealed the following:
-Written description of incident: Medication dose omitted from discharge papers received from the hospital;
-Cause : misread or didn't read;
-Analysis of incident: Resident returned from hospital with specific medication orders that were missed by the admitting nurse.

During an interview RPN #104 stated that when a resident came back from the hospital, two registered staff were to review the physician's order to minimize errors, transcribe the order and send to the pharmacy.

During an interview, Director of Nursing and Wellness #105 stated that resident #017 came back from hospital on a specific day in 2018, with a new medication order and the pharmacy caught the error the next day. Director of Nursing and Wellness further said that they would expect the two registered staff to check the previous order and new order and this was not done, which resulted in the medication error.

The licensee had failed to ensure that medications were administered to resident #017 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home’s Medication Incident Report & Analysis specifically dated, revealed the following:
-Written description of incident: Medication dose omitted from discharge papers received from the hospital;
-Reported to DOC only;
-Analysis of incident: Resident returned from hospital with medication orders that were missed by the admitting nurse.

A review of resident #017's clinical records showed no documented evidence that the medication errors were reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During an interview Director of Nursing and Wellness #105 stated that they were the only person notified of the error at the time and that the home's expectation would be that every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider were notified.

The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

Issued on this 19th day of November, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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) :	ALICIA MARLATT (590), CAROLEE MILLINER (144), CASSANDRA TAYLOR (725), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2018_532590_0017
Log No. / No de registre :	005388-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 3, 2018
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Berkshire Care Centre 350 Dougall Avenue, WINDSOR, ON, N9A-4P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bidarekere Swamy

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with r. 229. (5) (a) and (b) of the Ontario Regulation 79/10.
Specifically the licensee must:
a) Ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
(b) Ensure that on every shift symptoms are recorded and that immediate action is taken as required.

Grounds / Motifs :

1. The licensee had failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint IL-52525-LO was received by the Ministry of Health and Long-Term Care (MOHLTC) on August 21, 2017, from the Substitute Decision Maker (SDM) of resident #016, related to the number of infections this resident had since their admission to the long term care home on February 9, 2017.

In an interview with Director of Nursing and Wellness #105, they shared that resident #016 was on antibiotics several times for recurring urinary tract infections. The Director of Nursing and Wellness said that when a resident was on antibiotics, the registered staff were expected to complete and record vital signs in Point Click Care (PCC) every shift as part of the home's process for

monitoring infections.

Review of resident #016's clinical record showed that the resident was on antibiotics five different times from admission in February 2017, to their discharge in April 2018, for infections. The resident's latest care plan documented that this resident had impaired immunity related to infection and directed staff to monitor and document the resident's temperature in PCC every shift during antibiotic therapy. The documentation showed that there were times the resident was on antibiotics and was not monitored according to the home's processes.

Resident #016 was on antibiotics from March 20 to 27, 2017. Review of the progress notes and vital sign section in PCC, showed that vital signs were not documented on the following shifts: March 21 on afternoons, March 23 on nights and March 25 on days and nights.
Resident #016 was on antibiotics from March 29 to April 10, 2017. Review of the progress notes and vital sign section in PCC, showed that vital signs were not documented on the following shifts: March 31 on afternoons, April 1 on nights, April 3 on afternoons and nights, April 4 on days and nights, April 5 for all shifts, April 8 for days and afternoons and April 9 on days and afternoons.
Resident #016 was on antibiotics from April 19 to 28, 2017. Review of the progress notes and vital sign section in PCC, showed that vital signs were not documented on the following shifts: April 19 on nights, April 22 on days, April 23 on nights, April 24 on afternoons and nights, April 25 on days and nights, April 26 on afternoons and nights, April 27 on days and April 28 on nights.
Resident #016 was on antibiotics from May 22 to May 31, 2017. Review of the progress notes and vital sign section in PCC, showed that vital signs were not documented on the following shifts: May 23 on days, May 24 on days, May 25 for all shifts, May 26 on nights, May 27 on days and nights, May 28 on days and afternoons, May 30 on days and nights and May 31 on nights.
Resident #016 was on antibiotics from April 6 to discharge on April 18, 2018. Review of the progress notes and vital sign section in PCC, showed that vital signs were not documented on the following shifts: April 8 on days, April 9 on days, April 13 on days, April 16 on days and afternoons, April 17 for all shifts and April 18 on days.

In an interview with RPN #120 they said that when a resident was on antibiotics

vitals signs should be done every shift and documented in a progress note with a heading of infection and this was to be done until the antibiotics were completed.

In an interview with RPN #104, they said that vital signs should be completed every shift and documented in PCC, along with an infection progress note. The RPN said this monitoring should be continued until the antibiotics were completed.

In an interview with Assistant Director Of Care (ADOC) #142, they said that when residents' were on antibiotics, staff should be completing and documenting vital signs in PCC, along with a general assessment of how the resident was doing.

The licensee had failed to ensure that staff monitored symptoms of infection in resident #016 on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

2. Resident #022 was admitted to the home on a short stay program on July 12, 2018, and discharged to their home on July 16, 2018.

The clinical record for resident #022 stated that at 1329 hours on July 13, 2018, the resident's temperature was 38.3 Celsius (C).

The clinical record did not include the provision of a treatment for the resident's elevated temperature.

The resident's temperature was recorded again at 0203 hours on July 14, 2018, as being 36.2 C.

On July 16, 2018, at 1257 hours as resident #022 was preparing for discharge, their temperature was recorded as 38 C and an antibiotic was initiated for suspicion of a urinary tract infection.

The Power of Attorney (POA) for resident #022 shared with the inspector on September 7, 2018, during a telephone conversation, that resident #022 attended their personal physician's office on July 18, 2018, and was diagnosed

with a urinary tract infection.

Director of Nursing and Wellness #105 told the inspector that resident #022 should have been administered medication and or an alternate treatment for their elevated temperature on July 13, 2018, at 1329 hours. Director of Nursing and Wellness #105 further said that resident #022's temperature should have been monitored a second time on the day shift on July 13, 2018, and that depending on that result, possibly monitored into the evening shift of the same date.

The Director of Nursing and Wellness agreed that resident #022 did not receive care on July 13, 2018, that was consistent with their needs.

The licensee had failed to ensure that staff monitored symptoms of infection in resident #022 on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The severity of this issue was determined to be a level three as there was actual harm to a resident. The scope of the issue was a level one as it was identified as an isolated incident. The home had a level two compliance history of one or more unrelated non-compliance in the last 36 months.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 02, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 3rd day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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