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
Jan 16, 2020	2019_532590_0033	021017-19, 022976-19	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

Berkshire Care Centre
350 Dougall Avenue WINDSOR ON N9A 4P4

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

ALICIA MARLATT (590), JULIE DALESSANDRO (739)

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): December 9, 10, 12, 13, 16, 17 and 18, 2019.

During the course of the inspection, the inspector(s) spoke with Executive Director, the Director of Care, two Assistant Director's of Care, one Nurse Practitioner, three Registered Practical Nurses, three Registered Practical Nurses and one Personal Support Worker.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, staff and resident interactions, recreational activities, resident home areas and the general maintenance and cleanliness of the home.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, policies and procedures relevant to inspection topics, Infoline reports, Medication Incident Report and Analysis Forms and Risk Management reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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).

Findings/Faits saillants :

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

A complaint was received by the Ministry of Long-Term Care (MOLTC) identifying concerns regarding infection control, specifically related to the number of urinary tract infections (UTI) occurring in the home.

Review of resident #005's physicians' orders and progress notes showed that this resident suffered from frequent UTI's, requiring antibiotic therapy and hospitalizations. A three month review of the clinical record showed that the resident was admitted to the hospital with a diagnosis of UTI in 2019. The resident had a medical device initiated three days after returning from the hospital, for frequent UTI prevention. Antibiotic therapy for another UTI was started approximately three weeks after the initiation of the medical device. The resident was sent to the hospital two days later after the antibiotic therapy was started, and returned to the home the next day, continuing antibiotic therapy until their completion. During this time from when the medical device was initiated, until inspection date, the resident had been utilizing the medical device. The physician orders for the medical devices' care, written the same day it was initiated, were to change the device monthly and as needed. The home developed a care plan for resident #005 and it included that the device would be changed once a month, on a specific day, and as needed.

Review of resident #005's electronic Medication Administration Record (eMAR) for a specific month, showed an order for the medical device to be changed monthly and was due to be changed next on a specific date. The number two was observed in the area available for documentation on that day the device was due to be changed, which on the legend available, showed that the resident had refused the care. The inspector reviewed the corresponding progress notes on that day and found that the resident allowed only part of the device to be changed. The note stated that three attempts had been made with the resident to change the device and the resident continued to decline stating they did not want to be touched. The note further stated that the charge nurse had been made aware of the situation. There was no further documentation to date regarding any further attempts to change the device and their outcomes, any as needed device changes that were completed, or notes showing that the physician had been informed of the ongoing device change refusals.

Review of resident #005's hospital records available in the clinical record at the home, showed that the resident's device had not been changed while at the hospital for the two specified days.

In an interview with Director Of Care (DOC) #101, the inspector shared the above information with them. The DOC shared that they had the staff change the resident's device that day and that it was possible the staff thought it had been changed at the hospital, as the resident may have visited the hospital a couple times. The DOC shared that consistent changing of medical devices would prevent the occurrence or re-occurrence of UTI's and that follow up would be done with the staff involved. [s. 6. (7)]

2. A complaint was received by the MOLTC on a specific day. The complainant was concerned that the home did not transfer resident #001 to the hospital, after the physician ordered the transfer. The complainant reported that the resident was sent to the hospital two days after the physician wrote the order.

Review of resident #001's progress notes showed an entry on a specific day, written by Registered Practical Nurse (RPN) #103 that documented that the physician had sent the resident to the hospital, but the Assistant Director of Care (ADOC) directed staff to keep the resident at the home and monitor them there. The staff had not sent the resident to the hospital on that day, when the physician originally ordered the transfer, rather the resident was sent two days later. Review of the physicians' orders showed that on a specific day, the physician ordered a urine specimen to be obtained; there was no written order to send the resident to the hospital.

In an interview with RPN #103, they shared that they were concerned with resident #001's condition, as they had been working in the days prior and observed the resident to be drowsy and not themselves. The RPN shared that the residents' drowsiness continued and they contacted the physician about their concerns. The RPN shared that the physician ordered them to take a urine sample from the resident and call them back when it was obtained. The RPN obtained the urine sample and the Registered Nurse (RN) called the physician back to report the sample had been obtained. RPN #103 stated that they did not overhear the conversation the RN had with the physician over the phone, but stated that the ADOC was present. The RPN said that the RN and the ADOC spoke, that they were not aware of what was said between them, and was directed by them both to monitor the resident at the home.

In an interview with RN #109, they shared that they had called the physician after the urine sample for resident #001 had been obtained by the RPN. The RN stated when asked, that when they spoke with the physician on a specific day, that the physician had directed them to send the resident to the hospital. The RN shared that the ADOC was on the floor and was questioning why resident #001 was going to the hospital. The RN

stated that they shared their concerns of the resident being drowsy, and was directed by the ADOC to monitor the resident at the home, and not to send the resident to the hospital.

In an interview with ADOC #102 they shared that they had not directed staff to keep the resident at the home. The ADOC stated they had inquired with the registered staff about the outcome of their assessments. When the staff told them that they were concerned that the resident was drowsy, the ADOC stated that just being drowsy was not enough of a reason to be transferred to the hospital, as residents' can have good days and bad days, and stated that they requested the nurses to do further assessments. When asked if they were aware if the nurses had completed further assessments, or had communicated any further assessment findings to the physician, they stated that they were not sure if any further assessments were done, if the nurses contacted the physician with any updated assessment findings and/or when it was decided the resident was going to stay.

In an interview with DOC #101, they shared that they had investigated this incident. At the outcome of their investigation they determined that the physician's order on a specific day, to transfer resident #001 to the hospital had not been followed and should have been. [s. 6. (7)]

3. A complaint was received by the MOLTC from a complainant who was concerned in general, with follow up assessments not being completed resulting in unsatisfactory outcomes for residents at times.

Review of resident #001's progress notes showed this resident fell on a specific day in their room. A Personal Support Worker (PSW) was documented as having discovered/observed the fall. The note was documented by RN #107 that was on duty, writing that the "PSW called this writer and stated found resident sitting on floor mat leaning against bed." The note further documented that the resident was assessed and no injuries were observed by the nurse or reported by the resident at that time.

Review of a Risk Management report pertaining to resident #001's fall on that specific day showed a section titled Nursing Description. The description documented was the same progress note quoted above. In the witness section of the report, it was documented that there were none. The report also documented that there were no injuries at the time of the post-fall assessment.

Review of the homes' Falls Prevention Program, last revised in June 2018, stated that if there was evidence of a head injury, initiate the head injury routine immediately and follow the Head Injury Routine protocol.

Review of the Head Injury Routine policy, Index I.D: RCS E-35, last reviewed on July 10, 2018, stated that “The resident will be closely observed and assessed and vital signs will be monitored according to established guidelines subsequent to a head injury or a suspected head injury.”

In an interview with RN #107, they said that they were the nurse on duty the night resident #001 fell. The RN said that they did not witness the fall, but the PSW working came to them and reported they saw resident #001 fall. When asked about why the documentation in the resident’s record indicated the fall was not witnessed, when it was witnessed, they shared that it was an honest error on their part and should have documented that the fall was witnessed. When asked about the head injury routine not being completed, they said that they did not have to complete one, because the fall was witnessed. They shared that the home completed the head injury routine when a resident has a known head injury or if the fall was unwitnessed and the resident could not communicate if they hit their head or not.

In an interview with DOC #101 they shared that they thought the fall of resident #001 was witnessed by the PSW. They confirmed that the homes process was that unwitnessed falls had the HIR routine completed. They shared that a head injury routine had not been completed for resident #001’s fall that specific day. They could not explain why the documentation in the clinical record showed that the fall had not been witnessed, other than an error on the documentation.

The licensee had failed to ensure that the care set out in the plan of care for resident #001 and 005 was provided to the residents as specified in the plans. [s. 6. (7)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee had failed to ensure that the following immunization and screening measures were in place: Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

During this inspection, the complainant added to the concerns they initially reported. The complainant stated that they were concerned that newly admitted residents were not receiving their immunizations as required, specifically pneumococcus, tetanus and diphtheria.

According to the publicly funded immunization schedules posted on the Ministry website, Pneumovax 23 (pneumococcal polysaccharide 23) may be provided to those over 65 years of age and tetanus and diphtheria boosters may be provided every 10 years to those over the age of 34.

Record review of the home's Pneumovax Vaccine Policy, B-40, last revised March 27, 2019, stated under procedure that:
"-If the resident has not received the pneumococcal vaccine, consent from the substitute decision maker shall be obtained along with a physician's order to give the vaccine. -Give prescribed pneumococcal vaccine as ordered by the physician. -Document in the electronic notes in the immunization section that consent was given, the date when given, the lot number and the site where the vaccine was given. -If the resident was given the vaccine prior to admission, document in the electronic notes in the immunization section that consent was given, the date when given, the lot number and the site where the vaccine was given".

Record review of the home's Resident Health Promotion Program Policy, IFC B-05, last revised March 19, 2018, stated that tetanus and diphtheria was to be given every ten

(10) years, preferably combined.

During an interview with ADOC #110, who was the home's infection control lead, they stated that the home had an admission order set from pharmacy which had vaccines already listed and the nurse would ask the resident or family, if the resident was not capable, if they had received vaccines prior to entering the facility. If they had not received immunizations for pneumococcus, tetanus and diphtheria in the past and consent was given, it would have been checked off on the admission order set and sent to pharmacy before the vaccine would have been given. ADOC #110 also stated that the expectation would have been that the vaccines were administered within 24 hours of the admission orders being signed by the physician.

A) Record review of resident #004's clinical chart in Point Click Care (PCC) showed that they were older than 65 years of age and had been living at the home for approximately three months this year. The immunization tab in PCC revealed that the resident received their influenza immunization at the home, but there was no record of immunizations against pneumococcus, tetanus and diphtheria.

Record Review of resident #004's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #111, had the following checked off:
Pneumovax 23(pneumococcal polysaccharide 23) vaccine 0.5ml (millilitres) intramuscularly x 1 dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of progress notes in PCC from their admission to discharge in 2019, did not indicate that the resident was offered immunizations against pneumococcus, tetanus, and diphtheria.

B) Record review of resident #013's clinical chart in PCC showed that they were older than 65 years of age and had lived at the home for approximately two and a half weeks. The immunization tab in PCC revealed that the resident had no record of immunizations against pneumococcus, tetanus, and diphtheria.

Record Review of resident #013's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #112, had the following checked off:
Pneumovax 23 (pneumococcal polysaccharide 23) vaccine 0.5ml intramuscularly x 1

dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of available progress notes in PCC for resident #013 did not show that the resident was offered immunizations against pneumococcus, tetanus and diphtheria.

C) Record review of resident #014's clinical chart in PCC showed that they were older than 65 years of age and had been admitted to the home on a specific day in 2019. The immunization tab in PCC revealed that the resident had no record of immunizations against pneumococcus, tetanus and diphtheria.

Record review of resident #014's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #113, had the following checked off:
Pneumovax 23(pneumococcal polysaccharide 23) vaccine 0.5ml intramuscularly x 1 dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of progress notes in PCC for resident #014, written five and a half weeks after admission in 2019, did not indicate that resident was offered immunizations against pneumococcus, tetanus and diphtheria.

During an interview with DOC #101 they acknowledged that resident #004, #013, and #014 were not offered, nor had they received their admission immunizations against pneumococcus, tetanus and diphtheria. [s. 229. (10) 3.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. O. Reg. 79/10, s. 8 (1).

A complaint was called into the MOLTC Action Line reporting concerns about how many falls had occurred for resident #010. The complainant said they were specifically concerned about a fall with a fracture which occurred in the home and resident #010 had not been sent to the hospital until several days later.

Record Review of the home's Fall Prevention Policy, last revised in June 2018, stated in part that:
-Assessment of a fall should have been done immediately following the fall by the registered staff. The assessment and action taken were to have been documented in the falls assessment (Risk Incident Management).
-Communication with the substitute decision maker should have occurred after the fall. It is the responsibility of the registered staff to have provided accurate and timely information.
-Rehab/Restorative Therapist should have been notified of falls and would have completed a post-fall assessment as well.
-Post-fall assessment should have been done at a minimum every shift for the following twenty-four hours for potential complications from the fall. This assessment should have been documented in the electronic interdisciplinary notes.

During an interview with PSW #105, who was working the day the resident fell, stated that they found resident #010 sitting on the floor in the bathroom of another resident

room and had reported it to RN #104 right away.

Record review of a progress note in PCC showed a late entry documented a week later after the fall, stating that resident #010 had attempted to sit on the toilet and slid off onto the floor into a sitting position.

Record review of a progress note dated a week later after the fall stated that resident #010's X-ray result had revealed that they had a fracture. The following progress note in PCC dated eight days later indicated that resident #010 was admitted to the hospital with a hip fracture.

Record review of the risk management assessment in PCC indicated that RN #104 documented a post-fall assessment seven days after the fall occurred.

Record review of resident #010's clinical records showed that staff had not monitored resident #010 each shift for 24 hours after the fall, nor was there a Rehab/Restorative Therapist referral and assessment as per the home's falls prevention policy.

During an interview with RPN #100 they stated that they had not received report of a fall for resident #010 from RN #104 at shift exchange on that specific day, when RN #104 was leaving their midnight shift and RPN #100 was starting their day shift on the second floor.

During an interview with RN #104, who was working the day when resident #010 had fallen, they stated that they had not reported or documented the fall until five days after it had occurred. RN #104 also stated that they did not call resident #010's substitute decision maker, complete a risk management assessment, or complete a Rehab/Restorative Therapist referral until five days after the fall. RN #104 confirmed that they had not followed the home's fall prevention policy for resident #010.

During an interview with DOC #101, they stated that RN #104 stated that they had forgot to document resident #010's fall in PCC and had not reported the fall to RPN #100 who was coming onto the next shift. RN #104 also stated to DOC #101 that they completed the documentation one week later.

DOC #101 had also indicated that because the fall had not been reported, resident #010 was not monitored on each shift for 24 hours after the fall to determine if their behavior, functional or neurological status had changed, as per policy.

DOC #101 also stated that because the fall was not documented or reported until seven days after it had occurred, there was no referral or assessment completed by the Rehab/Restorative Therapist, as per policy.

DOC #101 also confirmed that resident #010's substitute decision maker was not notified of the fall until seven days later, when the home was made aware of it.

DOC #101 acknowledged that RN #104 had not complied with the home's fall prevention policy when resident #010 had fallen. [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 the falls policy is complied with, to be implemented voluntarily.

WN #4: 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 complaint was received by the MOLTC reporting concerns that physician's orders were being missed and pain medication was not being administered as ordered. The complainant reported one specific incident, where an order that had been missed was a pain medication for resident #002.

Review of resident #002's physician's orders showed that there was an order written on a specific day for an analgesic. The order stated to increase the frequency of the analgesic to twice a day, from the previous order of once a day. The eMAR showed that the analgesic order that was written on a specific day, had not been transcribed or administered to the resident, until over a week later.

There was a Medication Incident Report and Analysis Form completed for resident #002. The reports written description of the incident was that an order that was written on a specific day, to increase the frequency of an analgesic to twice a day for resident #002, was not processed until nine days later. The analysis of the incident was that the order was never processed and had not been 'flagged' for processing. The correction action plan stated that communication was sent out to all staff, that moving forward all new orders were to be flagged until the first and second checks were completed.

Review of the homes policy titled 'Transcribing Physician's Orders or RN (EC)'s Orders', index I.D: RCS F-65 and last revised on August 22, 2019, specifically stated that "physician orders are transcribed in a timely and systematic manner to reduce potential errors." Further, the policy stated that "Following the physician or RN (EC) visit, Night Charge Nurse/Nursing Supervisor checks all charts to ensure orders were not missed."

In an interview with Registered Practical Nurse (RPN) #108 they shared that the nurses completed the rounds with the physician or the Nurse Practitioner (NP) so the nurses knew when orders were left that need to be processed. The RPN said that if the nurse was busy for some reason and did not see an order being left, the order should be flagged by the physician or the NP and left at the nursing station for the nurses to complete when they were able. The RPN said that the night shift would review the charts for any missed orders by visualizing the flags left in the charts, and process any orders that had been missed.

In an interview with RN #107 they shared that the physician or NP was to flag any charts where they left orders for the nursing staff to follow up with. The purpose of the flag was to visually alert the nurse that the physician was in and left new orders. If any flags were missed during the day or afternoon shift, the night shift was responsible for ensuring that all flags and orders had been processed.

In an interview with Nurse Practitioner #106 they shared that they have always flagged the orders they leave in the resident's charts, they do this same practice at every long-term care home they attend.

In an interview with DOC #101 they shared that orders were to be transcribed as soon as possible after they were written. The DOC explained that any orders left were to be flagged by the writer of the order, so this would visually tell the nurse that changes had been made to the plan of care and they need to view the chart and update any orders. The DOC shared that this specific order for resident #002 had not been flagged and that was the reasoning for it being missed. The DOC stated that it was missed by the night shift checks as well, because it had not flagged. The DOC explained that the night shift was to check the charts for any missed flags, and it would be impossible to manually check every resident chart every night as the home has too many beds and limited registered staff on nights. The DOC stated that follow up had been completed with the practitioner who wrote the medication order. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 17th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), JULIE DALESSANDRO (739)
Inspection No. / No de l'inspection :	2019_532590_0033
Log No. / No de registre :	021017-19, 022976-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 16, 2020
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 :	Erica Hooker

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 Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically the licensee must:
a) Ensure that the medical device for resident #005, and any other resident with the identified medical device, is provided care as outlined in their plan of care and documented in their clinical records.

Grounds / Motifs :

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

A complaint was received by the Ministry of Long-Term Care (MOLTC) identifying concerns regarding infection control, specifically related to the number of urinary tract infections (UTI) occurring in the home.

Review of resident #005's physicians' orders and progress notes showed that this resident suffered from frequent UTI's, requiring antibiotic therapy and hospitalizations. A three month review of the clinical record showed that the resident was admitted to the hospital with a diagnosis of UTI in 2019. The resident had a medical device initiated three days after returning from the hospital, for frequent UTI prevention. Antibiotic therapy for another UTI was started approximately three weeks after the initiation of the medical device. The resident was sent to the hospital two days later after the antibiotic therapy was started, and returned to the home the next day, continuing antibiotic therapy until their completion. During this time from when the medical device was initiated, until inspection date, the resident had been utilizing the medical device. The physician orders for the medical devices' care, written the same day it was

initiated, were to change the device monthly and as needed. The home developed a care plan for resident #005 and it included that the device would be changed once a month, on a specific day, and as needed.

Review of resident #005's electronic Medication Administration Record (eMAR) for a specific month, showed an order for the medical device to be changed monthly and was due to be changed next on a specific date. The number two was observed in the area available for documentation on that day the device was due to be changed, which on the legend available, showed that the resident had refused the care. The inspector reviewed the corresponding progress notes on that day and found that the resident allowed only part of the device to be changed. The note stated that three attempts had been made with the resident to change the device and the resident continued to decline stating they did not want to be touched. The note further stated that the charge nurse had been made aware of the situation. There was no further documentation to date regarding any further attempts to change the device and their outcomes, any as needed device changes that were completed, or notes showing that the physician had been informed of the ongoing device change refusals.

Review of resident #005's hospital records available in the clinical record at the home, showed that the resident's device had not been changed while at the hospital for the two specified days.

In an interview with Director Of Care (DOC) #101, the inspector shared the above information with them. The DOC shared that they had the staff change the resident's device that day and that it was possible the staff thought it had been changed at the hospital, as the resident may have visited the hospital a couple times. The DOC shared that consistent changing of medical devices would prevent the occurrence or re-occurrence of UTI's and that follow up would be done with the staff involved.

The licensee had failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two of five residents reviewed. The home had a level 3 history as they had on-going

non-compliance with this section of the LTCHA that included:
- voluntary plan of correction (VPC) issued May 19, 2017 in Resident Quality Inspection #2017_531518_0006.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee must be compliant with r. 229. (10) 3 of the LTCH Regulation 79/10, 2007.

Specifically the licensee must:
a) Conduct an audit of the immunizations against pneumococcus, tetanus and diphtheria and identify any residents that were not immunized or not offered the immunizations, including resident's #004, #013, and #014 and ensure there is a documented record of the audit.
b) Offer the immunizations to any identified residents and document the date offered, if the resident consented or declined, and the date of administration if the resident consented.
c) Offer the immunizations to any new admissions and document the date offered, if the resident consented or declined, and the date of administration if the resident consented.

Grounds / Motifs :

1. 1. The licensee had failed to ensure that the following immunization and screening measures were in place: Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

During this inspection, the complainant added to the concerns they initially reported. The complainant stated that they were concerned that newly admitted residents were not receiving their immunizations as required, specifically pneumococcus, tetanus and diphtheria.

According to the publicly funded immunization schedules posted on the Ministry website, Pneumovax 23 (pneumococcal polysaccharide 23) may be provided to those over 65 years of age and tetanus and diphtheria boosters may be provided every 10 years to those over the age of 34.

Record review of the home's Pneumovax Vaccine Policy, B-40, last revised March 27, 2019, stated under procedure that:
"-If the resident has not received the pneumococcal vaccine, consent from the substitute decision maker shall be obtained along with a physician's order to give the vaccine. -Give prescribed pneumococcal vaccine as ordered by the

physician. -Document in the electronic notes in the immunization section that consent was given, the date when given, the lot number and the site where the vaccine was given. -If the resident was given the vaccine prior to admission, document in the electronic notes in the immunization section that consent was given, the date when given, the lot number and the site where the vaccine was given".

Record review of the home's Resident Health Promotion Program Policy, IFC B-05, last revised March 19, 2018, stated that tetanus and diphtheria was to be given every ten (10) years, preferably combined.

During an interview with ADOC #110, who was the home's infection control lead, they stated that the home had an admission order set from pharmacy which had vaccines already listed and the nurse would ask the resident or family, if the resident was not capable, if they had received vaccines prior to entering the facility. If they had not received immunizations for pneumococcus, tetanus and diphtheria in the past and consent was given, it would have been checked off on the admission order set and sent to pharmacy before the vaccine would have been given. ADOC #110 also stated that the expectation would have been that the vaccines were administered within 24 hours of the admission orders being signed by the physician.

A) Record review of resident #004's clinical chart in Point Click Care (PCC) showed that they were older than 65 years of age and had been living at the home for approximately three months this year. The immunization tab in PCC revealed that the resident received their influenza immunization at the home, but there was no record of immunizations against pneumococcus, tetanus and diphtheria.

Record Review of resident #004's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #111, had the following checked off:
Pneumovax 23(pneumococcal polysaccharide 23) vaccine 0.5ml (millilitres) intramuscularly x 1 dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of progress notes in PCC from their admission to discharge in

2019, did not indicate that the resident was offered immunizations against pneumococcus, tetanus, and diphtheria.

B) Record review of resident #013's clinical chart in PCC showed that they were older than 65 years of age and had lived at the home for approximately two and a half weeks. The immunization tab in PCC revealed that the resident had no record of immunizations against pneumococcus, tetanus, and diphtheria.

Record Review of resident #013's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #112, had the following checked off:
Pneumovax 23 (pneumococcal polysaccharide 23) vaccine 0.5ml intramuscularly x 1 dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of available progress notes in PCC for resident #013 did not show that the resident was offered immunizations against pneumococcus, tetanus and diphtheria.

C) Record review of resident #014's clinical chart in PCC showed that they were older than 65 years of age and had been admitted to the home on a specific day in 2019. The immunization tab in PCC revealed that the resident had no record of immunizations against pneumococcus, tetanus and diphtheria.

Record review of resident #014's paper chart document called, "Admission Orders" that were completed upon admission to the home and completed by Physician #113, had the following checked off:
Pneumovax 23(pneumococcal polysaccharide 23) vaccine 0.5ml intramuscularly x 1 dose (if not given anywhere else) and tetanus and diphtheria vaccine (Td) 0.5ml intramuscularly x 1 dose (for residents over 65 years).

Record review of progress notes in PCC for resident #014, written five and a half weeks after admission in 2019, did not indicate that resident was offered immunizations against pneumococcus, tetanus and diphtheria.

During an interview with DOC #101 they acknowledged that resident #004, #013, and #014 were not offered, nor had they received their admission

immunizations against pneumococcus, tetanus and diphtheria. [s. 229. (10) 3.]

The licensee had failed to ensure that resident #004, 013 and 014 were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 history as they had previous non-compliance to a different subsection. (739)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2020

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 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 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 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 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 16th day of January, 2020

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