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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2020	2020_777731_0005	019944-19, 001045-20, 001046-20	Follow up

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

KRISTEN MURRAY (731), JULIE DALESSANDRO (739), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 28, March 2, 3, 4, and 5, 2020.

The following Follow-up intakes were completed within this inspection:

Follow-up Log #001046-20 for Compliance Order (CO) #001 from Complaint Inspection #2019_532590_0033 related to plan of care.

Follow-up Log #001045-20 for Compliance Order (CO) #002 from Complaint Inspection #2019_532590_0033 related to immunizations.

Follow-up Log #019944-19 for Compliance Order (CO) #001 from Complaint Inspection #2019_777731_0026 related to housekeeping.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), an Assistant Director of Care (ADOC), the Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed auditing records and the home's documentation related to the compliance orders.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2019_777731_0026	731
O.Reg 79/10 s. 229. (10)	CO #002	2019_532590_0033	739

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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The licensee has failed to comply with compliance order #001 from inspection #2019_532590_0033.

The licensee was ordered to be compliant with s. 6 (7) of the LTCHA.

Specifically the licensee must:
a) Ensure that a specific intervention for a specified resident and any other resident with the specific intervention, is provided care as outlined in their plan of care and documented in their clinical records.

The licensee failed to complete step a) regarding ensuring any residents with a specific intervention was provided care as outlined in their plan of care.

Review of resident #055's clinical record showed use of the specific intervention. The physician orders indicated a specified intervention on specified days.

A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for specified months did not include this physician's order or documentation of the completed weekly task in relation to the specified intervention.

During an interview with resident #055 when asked how often the specified intervention was completed they responded it was never completed unless the resident asked staff to have the intervention completed.
Inspector #115 informed the resident that according to the physician's order and the plan of care a specified intervention was identified to be completed on specified days. The resident indicated that the intervention was not completed on the specified days.

In an interview with Registered Nurse (RN) #104 they stated that the intervention was completed per the physician's order and documented in the MAR, however RN #104 was unable to find the order in the MAR for specified months. When asked how staff would know this was completed and they indicated that it should be signed for by a registered staff in the MAR.

In an interview with Personal Support Worker (PSW) #105 when asked how often the specified intervention was completed for resident #055, the response was when the resident asked. The PSW confirmed that the resident was reliable.

During an interview with the Assistant Director of Care (ADOC) #102 they indicated that the physician's order for the specified intervention was not included on the MAR because it was not scheduled as a task on the MAR when the order was created. ADOC #102 also noted that the specified intervention days for resident #055 were incorrect and did not reflect what was written in the order and the resident's plan of care. They acknowledged that the care set out in the plan of care for resident #055's specified intervention was not provided to the resident as specified in the plan.

The licensee failed to ensure that care set out in the plan of care for resident #055 was provided to this resident as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 10th day of March, 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) :	KRISTEN MURRAY (731), JULIE DALESSANDRO (739), TERRI DALY (115)
Inspection No. / No de l’inspection :	2020_777731_0005
Log No. / No de registre :	019944-19, 001045-20, 001046-20
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 9, 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)

Linked to Existing Order / Lien vers ordre existant: 2019_532590_0033, CO #001;

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 specific care for resident #055, and any other resident with a specified intervention, is provided care as outlined in their plan of care and documented in their clinical records.

Grounds / Motifs :

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

The licensee has failed to comply with compliance order #001 from inspection #2019_532590_0033.

The licensee was ordered to be compliant with s. 6 (7) of the LTCHA.

Specifically the licensee must:
a) Ensure that a specific intervention for a specified resident and any other resident with the specific intervention, is provided care as outlined in their plan of care and documented in their clinical records.

The licensee failed to complete step a) regarding ensuring any residents with a specific intervention was provided care as outlined in their plan of care.

Review of resident #055's clinical record showed use of the specific intervention.

The physician orders indicated a specified intervention on specified days.

A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for specified months did not include this physician's order or documentation of the completed weekly task in relation to the specified intervention.

During an interview with resident #055 when asked how often the specified intervention was completed they responded it was never completed unless the resident asked staff to have the intervention completed.
Inspector #115 informed the resident that according to the physician's order and the plan of care a specified intervention was identified to be completed on specified days. The resident indicated that the intervention was not completed on the specified days.

In an interview with Registered Nurse (RN) #104 they stated that the intervention was completed per the physician's order and documented in the MAR, however RN #104 was unable to find the order in the MAR for specified months. When asked how staff would know this was completed and they indicated that it should be signed for by a registered staff in the MAR.

In an interview with Personal Support Worker (PSW) #105 when asked how often the specified intervention was completed for resident #055, the response was when the resident asked. The PSW confirmed that the resident was reliable.

During an interview with the Assistant Director of Care (ADOC) #102 they indicated that the physician's order for the specified intervention was not included on the MAR because it was not scheduled as a task on the MAR when the order was created. ADOC #102 also noted that the specified intervention days for resident #055 were incorrect and did not reflect what was written in the order and the resident's plan of care. They acknowledged that the care set out in the plan of care for resident #055's specified intervention was not provided to the resident as specified in the plan.

The licensee failed to ensure that care set out in the plan of care for resident #055 was provided to this resident as specified in the plan of care.

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to the resident. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 4 compliance history as they had a previous compliance order (CO) that included:
-Compliance order (CO) issued January 16, 2020 (2019_532590_0033) (115)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 20, 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 9th day of March, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kristen Murray

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