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
Oct 7, 2021	2021_790730_0033	009100-21, 012890-21, 014417-21	Critical Incident System

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

Banwell Gardens Care Centre
3000 Banwell Road Windsor ON N8N 0B3

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

CHRISTINA LEGOUFFE (730), MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 4, 5, and 6, 2021.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention:
Critical Incident Log #009100-21/ CI 2263-000014-21
Critical Incident Log #012890-21/ CI 2263-000017-21
Critical Incident Log #014417-21/ CI 2263-000019-21

An Infection Prevention and Control (IPAC) inspection was also completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Executive Director (ED), the Clinical Director of Care, an Assistant Director of Care (ADOC), a Housekeeper, the Registered Dietitian (RD), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and residents.

The inspector(s) 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, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

A resident had areas of impaired skin integrity. Weekly skin and wound reassessments were not completed.

A Registered Practical Nurse (RPN) said that the expectation in the home was that residents who were exhibiting areas of altered skin integrity should have been assessed weekly by registered nursing staff. They said that weekly skin assessments were not completed for the resident's areas of altered skin integrity.

There was a risk that the resident's areas of altered skin integrity would worsen in the absence of weekly skin assessments.

The home's policy titled "Skin and Wound Assessment" (revised June 2, 2021) said that the Point Click Care (PCC) Skin and Wound Application would be completed to evaluate the condition of the resident's skin at minimum every 7 days.

Sources: Resident clinical record including assessments and progress notes, the home's policy titled "Skin and Wound Assessment," and interviews with an RPN and other staff. [s. 50. (2) (b) (iv)]

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 a resident has an area of altered skin integrity they are reassessed at least weekly using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

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. (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 a resident was transferred as specified in their plan of care.

A resident was assessed to have specified transferring needs. The resident sustained a fall and was not transferred as per their plan of care.

A Registered Practical Nurse (RPN) said that resident had specified needs related to transferring. They said that staff should have followed the resident's plan of care when they transferred the resident after the fall.

There was a risk of harm to the resident when they were not transferred according to their plan of care.

Sources: Clinical record for a resident including assessments, plan of care, and progress notes and interviews with an RPN and other staff. [s. 6. (7)]

Issued on this 8th day of October, 2021

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

Original report signed by the inspector.