Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 14, 2024

Inspection Number: 2024-1061-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Banwell Gardens Care Centre, Windsor

Lead Inspector	**Inspector Digital Signature**
Stacey Sullo (000750)	Stacey Sullo Digitally signed by Stacey Sullo Date: 2024.05.14 10:32:59 -04'00'

Additional Inspector(s)
Julie D'Alessandro (739)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, May 1, 2, 3, 2024

The following intake(s) were inspected:

- Intake: #00103574 - 2263-000040-23 - Fall of resident.
- Intake: #00111557 - 2263-000010-24 - Alleged staff to resident abuse.
- Intake: #00113317 - 2263-000012-24 - Alleged resident to resident abuse.
- Intake: #00113389 - Complainant with laundry services and responsive behaviors.
- Intake: #00113851 - 2263-000013-24 Alleged resident to resident abuse.
- Intake: #00114416 - Improper treatment of resident.

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The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

Introduction

The licensee has failed to ensure that the resident received their ordered diet as set out in the Plan of Care.

Rationale and Summary

The residents care plan directed staff to provide them with a specific diet, however the diet ordered was not what the resident received.

During interviews with staff who confirmed the resident did not receive their ordered diet.

There was a risk to the resident, as resident was provided with a diet choice not ordered for them.

Sources: Critical Incident (CI:2263-000015-24), resident's electronic chart in point click care and staff interviews.

[000750]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Introduction

The licensee has failed to ensure that clear directions were given to staff and others who provided direct care to the resident.

Rationale and Summary

The resident's diet was changed by nursing staff, however the resident's electronic chart in Point Click Care (PCC) was not updated to reflect the change.

Confirmed during staff interviews that the resident's diet had been changed and not updated in their plan of care.

There was a risk to the resident, as the resident's diet had been changed and not updated in the resident's care plan therefore not all staff were aware of the resident's diet change.

Sources: Critical Incident (CI:2263-000015-24), resident's electronic chart, plan of care and staff interviews.

[000750]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

Introduction:

The licensee failed to ensure that there was a documented record kept in the home of a verbal complaint concerning the resident.

Summary and Rationale:

The resident had expressed concerns to the Long-Term Care home about the care they had received from a staff member, however after review of the home's client service response (CSR) binder, where the documentation related to concerns were kept, did not include documentation of this concern.

The staff acknowledged during interview that there was no documented record of the concern related to the residents concern kept in the home.

Sources: progress notes, CSR binder, and staff interview.

[739]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Introduction:

The licensee has failed to ensure that the Director was informed as per subsection 5, no later than one business day when resident was missing for less than three hours and who returned to the home with no injury or adverse change of condition.

Rationale and Summary

A resident had exited the Long-Term Care Home and was then returned to the home by staff.

Record review of the resident's progress notes in Point Click Care (PCC) stated resident had exited the Long-Term Care Home without informing the staff prior to leaving.

Confirmed during an interview with staff that the resident left the Long-Term Care home and staff were not aware resident had left the home.

There was a risk to the resident as staff were not aware resident was missing and had exited the home.

Sources:
Residents electronic chart, and staff interview.

[000750]