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

Hamilton District
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Original Public Report

Report Issue Date: January 24, 2024

Inspection Number: 2023-1050-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Cooksville Care Centre, Mississauga

Lead Inspector	**Inspector Digital Signature**
Brittany Wood (000763)	Brittany Wood Digitally signed by Brittany Wood Date: 2024.01.26 15:33:56 -05'00'

Additional Inspector(s)
Dusty Stevenson (740739)
Michelle Warrener (107)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
December 12, 2023
December 14-15, 2023
December 18-22, 2023

The following intake(s) was inspected in the Critical Incident (CI) section:
Intake #00100864/CI #2124-000035-23 related to falls prevention and management.
Intake #00099933/CI #2124-000033-23 related to safe and secure home.

The following intake(s) were completed in this inspection:

Intake: #00093883/CI#2124-000027-23 were related to falls prevention and management.

The following intake was completed in the compliant section:
Intake: #00101906 related to resident services and care, prevention of abuse and neglect and housekeeping, laundry and maintenance services.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
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
Duty of licensee to comply with plan
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.

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

Rationale and Summary
The physician ordered changes made to a resident's plan of care. On a few days in December, 2023 an assessment was only completed 1-2 times a day. During an interview with a staff, they stated that the resident will refuse treatment and that it is documented under the progress notes. There were no progress notes indicated that the resident refused the assessment or that the assessment was completed. A Clinical Director of Care (CDOC) confirmed that staff should have completed the assessment three times a day and that staff did not.

Failure to ensure that the care set out in the plan of care was provided for a resident led to an increased risk to the resident's skin integrity.

Sources: Interview with CDOC and a resident's clinical records. **[000763]**

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that actions taken with respect to a resident, under the falls prevention and management program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary:
A staff completed the post fall documentation for a fall and identified that paramedics gave instructions not to move the resident. The resident was transferred

from the floor, however, documentation in the resident's clinical record did not include the transfer. Documentation in the home's internal investigation notes reflected the resident was transferred from the floor while awaiting transfer to hospital.

A staff acknowledged that documentation in the resident's clinical record did not include how the transfer was completed.

Failure to document the transfer of the resident from the floor and method of transfer after the fall resulted in an incomplete record of events that occurred post fall.

Sources: A resident's clinical health record, including progress notes and post fall assessment; interviews with staff; and the home's internal investigation notes. **[107]**

WRITTEN NOTIFICATION: Required programs
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that their falls prevention and management program was implemented for a resident.

In accordance with Ontario Regulation, 246/22, s. 11. (1) (b), the licensee was required to ensure that their falls prevention and management policy was complied

with.

Specifically, staff did not comply with the policy, "Post-Fall Assessment" when a resident had a fall.

Rationale and Summary:
The home's Post Fall Assessment policy stated that if the registered staff assessing the resident did not believe the resident was safe to be transferred, the resident was not to be moved.

A registered staff instructed other staff not to transfer a resident from the floor to a surface but the instruction was not followed and the resident was transferred.

Moving the resident without the direction of the Registered staff may have placed the resident at increased risk of pain or injury.

Sources: Post-Fall Assessment policy RCS E-155, dated April 25, 2023, revised May 10, 2023; interview with staff; the home's internal investigation notes. **[107]**

WRITTEN NOTIFICATION: Infection Prevention and Control
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A) The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (e) point-of-care signage that enhanced IPAC control measures are in place.

LTCH Inspector observed a resident's room. There was no additional precaution signage at the entrance to the room nor in the resident's bathroom.

The resident's plan of care indicated that they required contact precautions for extended spectrum beta-lactamase (ESBL). A staff stated that the resident was on isolation for contact precautions.

Failure to have appropriate signage for the resident posed a risk to other residents for an increased chance of spreading the infection.

Sources: Observation of a resident's room, resident's clinical records and interview with staff. **[000763]**

B) The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional Personal Protective Equipment (PPE) requirements including appropriate selection and application.

LTCH Inspector observed a staff enter a resident's room to provide care. The resident had additional precautions for Extended Spectrum Beta-Lactamase

(ESLBL) that required donning of a gloves and gown. The staff completed hand hygiene prior to entering the room, however no gloves or gown were donned.

The home's policy titled, Management of ESBL stated the recommended steps when providing care to a resident who is on ESBL contact precaution. Specifically, the policy stated, wear a disposable gown for direct care. The staff confirmed they were not wearing a gown during the inspector's observation.

Failure to donn the correct PPE when providing care to a resident that is on ESBL contact precaution posed a risk of spreading infection to other residents.

Sources: Observation of staff, interview with staff and the home's policy titled Management of Extended Spectrum Beta-Lactamase ESBL (revised July 31, 2023). **[000763]**

WRITTEN NOTIFICATION: Infection Prevention and Control
NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that

all staff participate in the implementation of the Infection Prevention and Control program and must be complied with.

Specifically, staff did not comply with the policy "Management of Extended Spectrum Beta-Lactamase ESBL" revised July 31, 2023, which was included in the licensee's Infection Prevention and Control program.

Rationale and Summary
On a day in April, a resident was placed on contact precautions for Extended Spectrum Beta-Lactamase (ESBL). In October, the resident had a negative test result for ESBL. The home's ESBL policy stated that a resident with four negative specimens taken at least one week apart was considered negative and could be removed from precautions. The resident had one negative test result in their chart.

The IPAC lead confirmed that the ESBL swab testing was to be completed weekly four times with a negative test result for residents to be taken off of isolation and that if a resident only had one swab, they should have had the remaining three swabs to confirm whether the infection was still present.

Failure to test the resident for ESBL, put the resident at risk of an undetected continued infection and other residents at risk of infection transmission.

Sources: Interview with IPAC lead, a resident's clinical record, the home's policy titled Management of Extended Spectrum Beta-Lactamase ESBL (revised July 31, 2023). **[000763]**

WRITTEN NOTIFICATION: Emergency plans
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. viii.

Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
viii. situations involving a missing resident,

The licensee failed to comply with their plan for dealing with emergencies related to situations involving a missing resident.

In accordance with Ontario Regulation, 246/22, s. 11. (1) (b), the licensee was required to ensure that their emergency management plan was complied with.

Specifically, staff did not comply with the policy, "Code Yellow – Missing Resident – General", which was part of the home's emergency management plan for missing residents.

Rationale and Summary:
The home's Code Yellow, Missing Resident policy, directed staff to immediately implement the code yellow procedure upon discovering a resident was missing and the Unit Supervisor/delegate would page, "Code Yellow, name of the missing resident, room number" three times, as soon as staff were unsuccessful in locating a resident.

A resident left on a leave of absence (LOA) on a day in October 2023, with an expected return time. A staff notified the Charge Nurse that the resident had not returned from their LOA, and the Code Yellow process was initiated.

A staff confirmed the home's Code Yellow policy was not immediately initiated when the resident did not return from their LOA at the expected time, resulting in a

delay in initiating the search for the resident.

Sources: Interview with staff, Policy EPM F-05 Code Yellow – Missing Resident – General, dated June 1, 2000, reviewed dates of July 8, 2022; Progress notes; Code Yellow Report completed; LOA Sign Out form; CI report and hospital records for the resident. **[107]**