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: June 28, 2024
Inspection Number: 2024-1050-0001
Inspection Type: Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Cooksville Care Centre, Mississauga

Lead Inspector	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2024.07.02 12:24:23 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 14, 18, 19, 20, 21, 2024.

The following intake(s) were inspected:

- Intake: #00106805 - Critical Incident (CI) #2124-000004-24 - related to an alleged abuse of a resident
- Intake: #00111971 - CI #2124-000013-24 - related to an outbreak
- Intake: #00113484 - CI #2124-000020-24 - related to an alleged abuse of a resident

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly as clinically indicated.

Rationale and Summary
A resident acquired an altered skin integrity which has deteriorated. The records identified that the altered skin integrity was not reassessed on weekly basis for an identified period of time. The Wound Care Nurse confirmed that the altered skin integrity was not reassessed on weekly basis.

Failing to assess the altered skin integrity weekly may have increased the risk for wound deterioration.

Sources: Review of resident's clinical records and home's policy "Skin Care & Wound Management Program", (May 2022); interview with Wound Care Nurse and the Director of Care (DOC).
[561]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 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).

The licensee has failed to ensure that the Infection Prevention and Control Standard issued by the Director was implemented in the home related to additional precautions.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, section 9.1(f) states that the licensee shall ensure that Additional Precautions are followed in the IPAC program including at minimum appropriate selection, application, removal and disposal of personal protective equipment (PPE).

Rationale and Summary

A staff member was observed entering a resident's room to attend to them wearing a gown and a surgical mask. A droplet contact precautions sign was posted at the entrance to this resident's room. The staff member failed to don gloves and eye protection when entering the room. The IPAC lead stated that the expectation was that a full PPE was required when attending to a resident who was on droplet precautions.

Failing to don the appropriate PPE, may have increased the risk for the spread of infections.

Sources: Observations; review of resident's records, home's policy "Droplet contact precautions" (July 31, 2023); interview with the staff member, and the IPAC Lead. [561]