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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date: October 19, 2022
Inspection Number: 2022_1277_0001
Inspection Type:
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Anson Place Care Centre

Lead Inspector
Yvonne Walton ID#169

Additional Inspector(s)
Jennifer Allen ID#706480

Inspector Digital Signature
Yvonne Walton

Inspection Summary

The inspection occurred on the following date(s): July 19, 20, 21, 22, 25, 26, 27, 28, 29, August 2, 3, 4, 5, 2022

The following intake(s) were inspected:

-Complaint Intake #002378-22 related to skin and wound care, neglect, infection control.
-Complaint Intakes #018526-21, #018523-21, #018297-21, #018226-21, #017224-21, #016471-21, #002378-21 related to an outbreak, complaints, skin and wound care and abuse and neglect.
-Critical Incident Intake #001524-22 related to skin and wound care.

The following Inspection Protocols were used during this inspection:

- Continence Care
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management

- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

Inspection Results

Non compliance remedied: Cooling Requirements

NCR#01 pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 23(7)

The licensee has failed to ensure that all resident rooms were served by air conditioning by June 22, 2022.

Rationale and Summary

On July 19, 2022, various resident rooms were inspected, and temperatures noted to be greater than 27 degrees Celsius. The temperatures were obtained directly at the vent that enters resident rooms. Discussion with the maintenance staff, Director of Building Services and the HVAC provider confirmed the vents that enter resident rooms provides outside air only and does not provide air-conditioned air.

The licensee remedied the air conditioning on July 20, 2022. The lack of air conditioning was a low-risk issue as residents identified they were comfortable.

Sources

Interviews with residents, staff, management, HVAC consultant, review of the clinical temperature records and evidence from inspector temperature checks occurred over several days to confirm there was no air conditioning serving resident rooms.

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WRITTEN NOTIFICATION DUTY TO PROTECT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 24 (1).

The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

Rationale and Summary
Two residents developed a medical problem. The home attempted to determine the cause of the medical problem and sent diagnostic tests to the Public Health Unit Laboratory. The results of the diagnostic tests from the Public Health Unit Laboratory were inconclusive due to very little material received in the specimen to properly generate a diagnosis. The home was advised by the lab to repeat the diagnostic test. Four days later the result also came back as inconclusive, due to insufficient material for proper testing. Public Health also provided additional instructions to resubmit an adequate specimen.

No further diagnostic tests were performed until 25 days later.

Residents experienced a negative response as a result of their delayed diagnosis and subsequent treatment.

Interviews with staff revealed there was a long delay between when the diagnostic tests were performed in October 2021 and when the treatments were given to the residents in November.

The home failed to continue testing until the results yielded a definitive result.

Sources:
Public Health Unit Laboratory; progress notes for residents, interviews with staff, the physician, and the DOC.

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Written Notification skin and wound

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 55 (2)(b)(iv).

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

Rationale and Summary

A) A resident had an alteration in skin integrity. The intervention included an assessment and evaluation of the skin condition weekly. The resident was treated preventatively, however, there was no weekly skin evaluations noted for the treatment for three weeks.

B) Another resident had an alteration in their skin integrity. There were two missing weekly skin assessments.

C) Another resident had an altered skin integrity issue. Three consecutive weekly skin assessments were not completed

The Director of Care (DOC) confirmed the homes expectation was that the evaluation for treatment effectiveness was to be completed every couple of days and a progress note should be documented with the “Skin Note” heading. The DOC also confirmed the resident's altered skin integrity should have had a progress note evaluation.

Failure to assess and evaluation the skin conditions and treatment evaluation for residents on a weekly basis may have increased the risk of delay in healing and establishing proper treatment.

Sources:
Resident care plans, progress notes, electronic medication administration record and electronic treatment administration records, physician orders, and interview with the DOC.

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