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

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Original Public Report

Report Issue Date: December 22, 2023
Inspection Number: 2023-1277-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Anson Place Care Centre, Hagersville

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.12.29 11:07:39 -05'00'

Additional Inspector(s)
Lisa Vink (168)
Leah Curle (585)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 6-8, 11-12, and 14-15, 2023.

The following intake was inspected:
Intake: #00102836 for a Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to a resident.

Rationale and Summary

The plan of care identified a diet for a resident with two different food textures.

The Registered Dietitian (RD) confirmed that the plan of care was not accurate related to the resident's diet texture.

The resident's plan of care was amended related to their nutritional interventions to provide clear directions to staff.

Sources: Plan of care, diet orders and meal service report for a resident and interview with the RD and other staff. [168]

Date Remedy Implemented: December 12, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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.

The home has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

A review of a resident's plan of care indicated an intervention and required staff to document for the specified intervention. However, there were no documentation in point of care (POC) about the intervention.

The Director of Care (DOC) explained that the intervention indicated that the resident was able to do the intervention by themselves, and that it was not a task for staff to document.

The DOC amended the resident's plan of care to provide clear directions to staff.

Sources: Interview with the DOC; Review of a resident's care plan. [740741]

Date Remedy Implemented: December 15, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer.

Rationale and Summary

A resident was assessed by the registered dietitian (RD), who determined the resident no longer required a dietary restriction.

The Meal Service Report still listed specific foods related to the dietary restriction which the resident was not to be offered.

The Meal Service Report was later updated and no longer included the dietary restrictions for the resident.

Sources: Meal Service Reports, Interdisciplinary Plan of Care Review, interview with the RD and other staff. [585]

Date Remedy Implemented: December 12, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that the plan of care for a resident was revised when the care set out in the plan was no longer necessary.

Rationale and Summary

A resident was assessed by the registered dietitian (RD), who determined a diet for the resident and a Meal Service Report identified the resident was to avoid the diet.

The Meal Service Report was updated to reflect the resident's diet.

Sources: Meal Service Report, progress notes and plan of care for a resident and interview with the RD. [168]

Date Remedy Implemented: December 12, 2023

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
Required information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act included an explanation of the whistle-blowing protection.

Rationale and Summary

A binder was noted in the main lobby that included a document explaining the whistle-blowing protection under the Long-Term Care Home Act.

The Infection and Prevention Control (IPAC) lead confirmed that the home did not have an explanation of the whistle-blowing protection posted, and that the information included in the binder was pertaining to the old legislation.

An explanation of the whistle-blowing protection consistent with the requirements under the FLTCA was then posted in the home.

Sources: Observation of the home for mandatory postings; Interview with the IPAC lead. [740741]

Date Remedy Implemented: December 15, 2023

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act included the visitor's policy.

Rationale and Summary

The visitor's policy was not observed to be posted in the home. The IPAC lead confirmed that the home did not post their visitor's policy.

The home's visitor's policy was then posted in the home.

Sources: Observation of the home for mandatory postings; Interview with the IPAC lead. [740741]

Date Remedy Implemented: December 15, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #007 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.

A) 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 plan of care for a resident identified a nutritional intervention.

During a meal service the resident was served a drink not as per the resident's plan of care.

The Food Service Manager (FSM) confirmed that the nutritional intervention was not available during that meal service.

Sources: Observation of meal service, review of the plan of care and interviews with the FSM and other staff. [168]

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

Rationale and Summary

A resident had a fall.

Registered staff could not confirm if a falls intervention was in place for the resident at the time of the fall.

Failure to have the falls intervention in place put the resident at risk of falls.

Sources: Interview with registered staff; Review of the residents' progress notes and care plan. [740741]

WRITTEN NOTIFICATION: Directives by Minister

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational

or policy directive that applies to the long-term care home.

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every operational Minister's Directives that applies to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the Licensee was required to have enhanced measures in place in outbreak areas whereby staff clean and disinfect frequently touched surfaces, using at a minimum a low-level disinfectant, at least twice daily.

Rationale and Summary

The Minister's Directive stated that when the home is an outbreak, the home is to have enhanced measures in place in outbreak areas whereby staff clean and disinfect frequently touched surfaces, using at a minimum a low-level disinfectant, at least twice daily.

The home was confirmed for a covid-19 outbreak on November 3, 2023, and the outbreak was declared over on November 22, 2023.

A housekeeping staff stated that frequently touch surfaces were cleaned once or twice daily during the home's last outbreak in November 2023.

Interview with the IPAC lead, confirmed that there was a procedure in place for staff to clean and disinfect frequently touched surfaces at least twice daily when the home was in an outbreak, however, documentation was missing on November 18 and 19, 2023, in the home's "High Touch Pint Cleaning Checklist" for the west side of the long-term care floor.

The residents were placed at increased risk of COVID-19 transmission when the staff did not complete cleaning and disinfecting frequently touched surfaces at least twice daily when the home was in an outbreak, in accordance with the Minister's Directive COVID-19 response measures for long-term care homes.

Sources: Interview with the IPAC lead and staff; Minister's directives: COVID-19 response measures for long-term care homes April 27, 2022. [740741]

WRITTEN NOTIFICATION: Doors in a home

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors which lead to non-residential areas were equipped with locks which restricted unsupervised access to those areas by residents, and that doors were kept closed and locked when not supervised by staff.

Rationale and Summary

Some rooms/doors in the basement were not kept locked and were unattended by staff.

The Administrator acknowledged that a few doors in the basement were not equipped with a lock, but that all doors in the area were to be kept closed and locked when not supervised by staff.

The home previously had a retirement home on the first floor. Portions of the first floor could be accessed, during office hours, during the inspection as some rooms/areas were converted to office space for long-term care staff. The stairwell on the first floor was not secure.

The Administrator acknowledged that doors on the first floor were left unlocked and unattended at certain times during the day; however, that the area, including the stairwell, was secured and locked during the evenings and weekends.

Elevator access to the basement was not secured. The basement could be accessed from the front lobby elevator without a code and elevator access, specifically to the basement, was not secured. Two residents were observed to enter the basement from the elevator, unaccompanied by staff.

Failure to restrict access to non-residential areas of the home had the potential for residents to access areas which were not secured and for other persons to access and gain entry to areas of the home without the knowledge of staff.

Sources: Interview with the Administrator and staff; Observations of the home's basement and former retirement home area. [740741]

WRITTEN NOTIFICATION: Communication and response system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Rationale and Summary

Call bells were noted to be missing in the basement hair salon, the physiotherapy room and the lobby on the main floor. A resident was observed unattended in the hairdresser's room.

The Administrator also noted that both rooms and the lobby would be occasionally used by residents and that residents could be left unattended, and confirmed that those areas were not equipped with a call bell system.

By the home failing to have a resident-staff communication and response system that was available in every area accessible by residents in the home, put the residents at risk.

Sources: Interview with the hairdresser and the Administrator; Observations of the hair salon and the physiotherapy room in the basement. [740741]

WRITTEN NOTIFICATION: Menu Planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that, prior to being in effect, each menu cycle, was evaluated by the registered dietitian (RD) who was a member of the staff of the home.

Rationale and Summary

The Food Service Manager (FSM) identified that the current fall/winter menu was implemented on a specified date; however, due to staffing turnover, it was not evaluated by an RD who was a member of the staff of the home.

Failure to have the RD evaluate the menu had the potential for the menu to not be nutritionally adequate.

Sources: Discussion with the FSM and the RD. [168]

WRITTEN NOTIFICATION: Menu Planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning

s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

A) The licensee has failed to ensure that all planned menu items were available at a meal service.

Rationale and Summary

The planned and posted menu for the noon meal on a specified date, included a fruit option for dessert.

The dessert was not available for residents on a regular textured diet.

Sources: Dining observation of noon meal, planned menu and a resident's diet order, interview with staff. [585]

B) The licensee has failed to ensure that the planned menu item was offered and available at a meal service.

Rationale and Summary

The planned and posted menu for the noon meal on a specified date, included an option for dessert.

A dietary aid confirmed that the dessert was not available for those on a texture modified diet.

Sources: Observations of the noon meal, review of the posted menu and therapeutic menu and interviews with a dietary aid and other staff. [168]

WRITTEN NOTIFICATION: Housekeeping

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (1)
Housekeeping
s. 93 (1) Every licensee of a long-term care home shall ensure that housekeeping services are provided seven days per week.

The licensee has failed to ensure that housekeeping services were provided seven days per week, specifically on November 27, 2023.

Rationale and Summary

The housekeeping schedule identified that a staff member was scheduled to work on a specified date; however, the shift was crossed off. The schedule did not include that another staff member was reassigned the shift.

The Office Manager confirmed that the home did not have housekeeping coverage on that date, the assigned housekeeper was unable to work and the home was unable to fill the shift. Personal Support Worker (PSW) staff assisted and cleaned the dining rooms and emptied the garbage.

Failure to provide housekeeping services seven days a week resulted in areas to not be cleaned as required.

Sources: Review of housekeeping schedules, housekeeping checklists and interviews with the Office Manager and other staff. [168]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #014 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 (IPAC) Standard, April 2022, issued by the Director was complied with.

Rationale and Summary

Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) (iii) related to routine practices was complied with for at a minimum use of administrative controls including but not limited to, comprehensive IPAC policies and procedures.

Staff failed to clean a ceiling lift after resident use. The staff stated the expectation was to clean the mechanical lift after every use using Oxivir wipes.

A review of the home's policy titled Cleaning of Medical/Personal Care Equipment and Contact Surfaces did not provide instructions on how to clean a ceiling lift or the frequency for cleaning, but stated to use Virox wipes as a disinfectant. The IPAC lead confirmed that the home did not have policies and procedures related to cleaning of ceiling lifts.

Failure to have comprehensive policies and procedures related to the use of environmental controls for cleaning had the potential to increase the risk of spreading an infection.

Sources: Observations of residents; interview with the IPAC lead and other staff. [740741]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that at least one personal support worker (PSW) was part of the continuous quality improvement (CQI) committee.

Rationale and Summary

In an interview with the Quality Improvement lead they acknowledged that the CQI committee did not include at least one PSW.

Sources: Interview with the Quality Lead and a review of meeting minutes. [168]