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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 3, 2022	
Inspection Number: 2022-1077-0001	
Inspection Type: Critical Incident System	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Orchard Terrace Care Centre, Stoney Creek	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature**
Additional Inspector(s) Jonathan Conti (740882) Pauline Waldon (741071)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 5, 6, 7, 11, 12, 13, 14, 17, 2022.

The following intake(s) were inspected:

- Intake: #00004616, was related to an allegation of neglect.
- Intake: #00006210 was related to a fall of a resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect

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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)
O.Reg. 246/22, s. 102 (2)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), was implemented.

Rationale and Summary
According to the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were to ensure that personal protective equipment (PPE) requirements, were followed.

The home's policy stated that the required PPE were to be placed at the entrance of the affected resident's room; and that the required PPE for droplet contact precautions were gowns, gloves, procedure or surgical mask, eye protection (goggles) or face protection (shield), and N95 respirator, if required based on Point of Care Risk Assessment.

On an identified date and time, a room on droplet and contact precautions, was observed not having gowns or surgical masks at the entrance of the resident's room.

Staff indicated that the cart was not refilled after the supplies were used up, and they immediately refilled the cart with gowns and surgical masks.

Sources: Observation of care; Minister's Directive: COVID-19 response measure for long-term care homes; home's Infection Prevention and Control: Droplet Contact Precautions, last reviewed Aug 11, 2022; interview with staff.

[748]

Date Remedy Implemented: October 6, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The licensee 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 provided direct care to the resident related to their level of assistance required.

Rationale and Summary
A resident had been assessed as a high fall risk, and had a history of falls as a result of attempting to complete their own personal care task. The resident fell three times on an identified month, with their third fall, resulting in hospitalization and change of level of assistance needs.

The resident's care plan was revised indicating that the resident required assistance from staff related to a personal care task. In another area of their care plan; it stated that the resident was able to complete the task on their own. These two different directions were in place at the time of the resident's third fall on the identified month.

Staff #113 and staff #114 indicated that the interventions were not consistent with resident needs and not clear, when they reviewed the resident's care plan after the resident fell.

Staff #110 and staff #112 were not able to indicate the resident's assistance level, when they had multiple falls; however, they indicated that they would have checked the care plan and Kardex tasks to determine the level of assistance needed.

There may have been a potential increased risk for falls when the resident was not provided the appropriate care due to unclear directions in their care plan.

Sources: Resident’s care plan; progress notes; critical incident report; interviews with staff #113 and #114; internal risk management reports; resident’s Fall Assessment Tools.

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WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan related to activities of daily living for locomotion in their assistive device.

Rationale and Summary
During observation of a resident by the nursing station, an equipment for their assistive device had been applied. The plan of care for the resident stated that the equipment was to be removed at that time.

Staff #112 and #114 identified that the resident had risk related to the use of their assistive device. Staff #114 identified the equipment on the assistive device should have been removed as there was a risk of injury if they were applied at certain times.

The resident was high risk for falls, and they may have been at an increased risk of injury due to their plan of care not being followed.

Sources: Residents' observation; interviews with staff #112, staff #114; care plan interventions and fall assessments for resident.

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WRITTEN NOTIFICATION: Plan of Care- when reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and plan of care revised when the resident's care needs changed, or care set out in the plan of care was no longer necessary for use of an equipment.

Rationale and Summary
A resident's most recent fall assessment indicated high risk of falls. Interventions in place for high fall risk as care planned included use of a certain equipment, and a reminder and encouragement to use the equipment. The resident's care plan stated they can indicate when they needed to have personal care, however, it did not specify how.

Staff stated during interviews that the resident would indicate need for personal care by verbally informing staff. Staff #113 and #114 stated the resident had not been observed to use the equipment in place. Staff #111, #112 and #114 were able to identify other fall risk interventions as currently care planned, however the equipment was not mentioned by staff as an intervention.

Care plan revision occurred post-fall on an identified date; however, the use of the equipment remained in place at time of inspection when no longer necessary based on interviews with staff.

Risk and impact to resident was low as other fall interventions remained in place.

Sources: Resident's room observation; interviews with staff #110, staff #111, staff #112, staff #113, staff #114; care plan interventions and fall assessments for resident.

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