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
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 21, 2023

Inspection Number: 2023-1077-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Orchard Terrace Care Centre, Stoney Creek

Lead Inspector	**Inspector Digital Signature**
Barbara Grohmann (720920)	Barbara Grohmann 2023.12.21 16:13:46 -05'00'

Additional Inspector(s)
Melody Gray (123)
Olive Nenzeko (C205)
Erin Denton-O'Neill (740861)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 21, 24-28, 31; August 1-4, 8-9, 11, 16-18, 21-25, 29-31; September 1; and, December 6-8, 11-12, 14-15, and 18, 2023.

The following intakes were inspected in this complaint inspection:

- Intake: #00091714 was related to air temperatures; and,
- Intake: #00101636 was related to elopement, doors in the home, resident monitoring and falls prevention and management.

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The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00001730 [CI: 2477-000009-22], was related to alleged resident to resident physical abuse,
- Intake: #00001872 [CI: 2477-000010-22], was related to alleged resident to resident physical abuse,
- Intake: #00005622 [CI: 2477-000012-22], was related to staff to resident verbal abuse,
- Intake: #00089078 [CI 2477-000008-23], was related to falls prevention and management; and
- Intake: #00100678 [CI 2477-000014-23], was related to falls prevention and management.

The following intakes were completed in this inspection:

- Intake: #00021696 [CI 2477-000005-23]; and,
- Intake: #00019542 [CI 2477-000004-23], were related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Safe and Secure Home

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 the care set out in the plan of care was provided to a resident as specified in their plan related to falls.

Rationale and Summary
A resident's plan of care for falls stated that the resident required their wheelchair in a specific position and that if it was not, for any reason, staff were to ensure that the resident was in their eyesight.

While the resident was under the care of a personal support worker (PSW), the resident fell which resulted in injuries. The home's investigation concluded that the wheelchair was not positioned according to the plan of care when the PSW stepped away, with the resident out of their sight.

The Interim Director of Care (IDOC) confirmed that the PSW did not follow the resident's plan of care.

Failing to follow the resident's plan of care for falls resulted in harm when the resident sustained a fall with injuries.

Sources: CI #2477-000014-23, resident's clinical records, investigation notes, and interview with IDOC. [C205]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse by anyone.

Ontario Regulations (O. Reg.) 246/22 s. 2 (1) defined verbal abuse as any form of verbal communication of a threatening nature which diminishes a resident's sense of well-being, dignity or self-worth, made by anyone other than a resident.

Rationale and Summary
A security guard, contracted to provide one to one (1:1) supervision to another resident, was preparing to leave the home area when the resident told the 1:1 not to touch something, that it belonged to them. The 1:1 began yelling at the resident. After several attempts, the staff got the 1:1 to stop yelling and leave the home area.

The home's investigation notes documented that after 10-15 minutes, the 1:1 returned to the home area, and continued to yell at everyone present, including the resident. In written statements, staff alleged the 1:1 pointed at the resident #002, threatened them and staff before they were finally escorted out of the home area and building.

An RN described the 1:1 as verbally abusive and aggressive. They explained that during the altercation, the resident was upset, scared and teary eyed. The RN was able to calm down the resident after several minutes once the 1:1 left the home area and building.

The Executive Director (ED) acknowledged the verbal abuse had occurred. They explained that the contract with the security agency was cancelled, and that individual involved did not return to the home.

Failure to protect a resident from verbal abuse by a contracted staff member may have resulted in emotional trauma.

Sources: resident's clinical records; interviews with the ED and other staff. [123] [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately comply with section (s.) 28 (1) 2 of the Fixing Long-Term Care Act (FLTCA) in that a person, who has reasonable grounds to

suspect abuse of a resident by anyone, failed to report the alleged abuse immediate to the Director in accordance with the FLTCA.

Pursuant to FLTCA, s. 154 (3), the licensee was vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary
A resident was found on the floor in their room and alleged to a PSW that they were pushed by another resident.

CI report 247-000009-22, documented that the incident was reported to the Director two days after the alleged incident. The report also indicated that the Ministry's after-hours line was not used to report the incident when it occurred, and the allegations were made.

The ED acknowledged that the timing of the CI submission did not meet the reporting requirements. They stated that the RN did not follow the home's process of contacting the on-call manager, sending an email instead.

Failure to immediately notify the Director of abuse allegations had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: resident's clinical records, CI 2477-000009-22; interview with the ED. [123] [720920]

WRITTEN NOTIFICATION: Doors in a Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failure to ensure that outside doors were closed and locked.

Rationale and Summary:
A resident went missing from the home and was found outside. The back door of the home had been left open, which was confirmed by the ED. There was potential risk to the resident while they were outside alone.

Sources: resident's clinical records, interview with ED. [740861]

WRITTEN NOTIFICATION: Doors in a Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii. A.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system

The licensee failed to ensure that an outside door was alarmed and connected to the resident-staff communication and response system.

Rationale and Summary:
On a specific day, the outside exit door was not alarmed. This was confirmed by a PSW and the ED.

Sources: observation by inspector and interviews with staff. [740861]

WRITTEN NOTIFICATION: Air Temperatures

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary:
The home's temperature monitoring records were reviewed and indicated multiple instances where temperatures below 22 degrees Celsius were recorded. The accuracy of the information was confirmed during an interview with the ED. The low temperature posed a risk of discomfort to the residents.

Sources: Blue Rover Temperature logs June 12- August 6, 2023, interview with ED. [123] [740861]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to comply with monitoring of a resident after they stated they fell and hit their head.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a fall prevention and management program that provides strategies to mitigate falls, including the monitoring of residents, and must be complied with.

Specifically, staff did not comply with the policies "Fall Management" and "Head Injury Routine Policy" which were included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
The home's fall management policy required documented evidence that all residents are assessed post fall and monitored every shift for 72 hours. The head injury routine (HIR) policy directed registered staff to monitor vital signs and level of consciousness and document on a neurological flow sheet a specific time schedule.

A resident was found on the floor in their room. They alleged that another resident had pushed them, causing them to fall and hit their head. Registered staff initiated post fall monitoring, including a head injury routine.

A review of post fall monitoring progress notes showed that documentation was completed for only four of the required nine shifts. Vital signs and level of consciousness were not documented on the neurological flow sheet for the day and evening shifts on the last day of monitoring.

The falls lead recognized that not all post fall monitoring progress notes or neurological monitoring were not completed for the resident's fall.

Failure to complete the post fall monitoring as required may have resulted in staff not identifying complications if the resident had sustained a head injury.

Sources: resident's clinical records, Fall Management (revised September 2019, reviewed May 2023), Head Injury Routine policy (RCS E-35, reviewed December 2023); interviews with the ED, Falls Lead and other staff. [720920]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee has failed to ensure that interventions to minimize the risk of altercations between and among residents were fully implemented related to a

resident's responsive behaviours.

Rationale and Summary

A. An RN explained that the resident frequently wandered the hallways and would end up in other residents' rooms. The resident's care plan identified wandering as a responsive behaviour and included an intervention to redirect them away from other residents' rooms.

The resident was found in another resident's room on two different occasions which resulted in an altercation between the two, both times. A different resident told staff that the resident entered their room, which resulted in a verbal altercation.

B. Progress notes indicated that dementia observation system (DOS) charting was initiated for the resident after an altercation. A Behavioural Supports Ontario consultant documented that the staff were doing DOS charting. The DOS charting reference in the progress notes was not located while reviewing the resident's chart.

The ED acknowledged that the resident had entered the other residents' room which resulted in the altercations. The ED was unable to provide the DOS charting that was documented in the progress notes.

Failure to fully implement interventions for responsive behaviours to minimize the resident of altercations may have resulted in harm to the resident and/or other residents.

Sources: three residents' clinical records; interviews with the ED and other staff. [123] [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically a COVID-19 outbreak.

Rationale and Summary
CI 2477-000016-23 was first submitted to the Director the day after public health declared a COVID-19 outbreak in the home. The CI did not include a Service Ontario After-Hours Line report number.

The ED acknowledged that the report was not submitted immediately as required, stating that they believed it had been submitted the day prior.

Failure to immediately notify the Director of a disease of public health significance occurring in the home had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: CI 2477-000016-22; interview with the ED. [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee failed to ensure that the Director was informed of a resident who was missing from the home for less than three hours, no later than one business day after the occurrence of the incident.

Rationale and Summary:
A resident was missing from the home and was found in the outside parking area. The resident was uninjured. The home did not report the incident to the Director. The ED confirmed this and confirmed that they were aware of the requirement to report.

Sources: resident's progress notes, interview with ED, Critical Incident policy (IDRCS E-45, March 2001). [740861]