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: June 7, 2024	
Inspection Number: 2024-1077-0002	
Inspection Type: Critical Incident	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Orchard Terrace Care Centre, Stoney Creek	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2024.06.11 14:17:09 -04'00'
Additional Inspector(s) Erin Denton-O'Neill (740861)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-31 and June 3, 2024

The following intake(s) were inspected:

- Intake: #00103599 -Critical Incident (CI) 2477-000017-23- Improper/Incompetent treatment of resident.
- Intake: #00103853 -CI 2477-000018-23- Physical abuse to resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right to have their participation in decision-making respected.

The licensee has failed to ensure that a resident had their right to participation in decision-making respected.

Rationale and Summary
A resident indicated that they were not agreeable to the personal care that was being provided to them and staff continued to perform the care. The interim Director of Care (DOC) confirmed that the resident's right to participate in decision making was not respected.

Failure to ensure that the resident's right to participate in decision making was not respected, resulted in the resident receiving care that they did not consent to.

Sources: Resident's clinical records, interviews with staff, internal investigation notes and CI 2477-000018-23, policy-Residents' Bill of Rights RCS-P05. [740861]

WRITTEN NOTIFICATION: Duty to protect

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 physical abuse by a Registered staff.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "physical abuse" as (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
On a specified date in December 2023, a resident required a procedure to alleviate a health concern. Direct Care staff stated that a Registered staff performed the procedure forcefully and without explaining the procedure to the resident.

During the procedure, Direct Care staff witnessed that the resident was experiencing pain and discomfort. A staff stated that they told the nurse to stop the procedure.

Failure to ensure that a resident was protected from physical abuse by a Registered staff led to resident pain and discomfort.

Sources: CI 2477-000017-23, interviews with Direct Care staff. [740738]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of improper or incompetent care was reported to the Director immediately.

Rationale and Summary
On a specified date in December 2023, the home submitted a CI report for improper/incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The incident had occurred three days prior.

Interviews with Direct Care staff, who witnessed the incident, revealed that they both did not report the incident to the leadership team immediately. There were four Direct Care staff present during the incident.

Failure to report certain matters to the Director immediately can increase the risk of further incidents.

Sources: CI: 2477-000017-23, interviews with staff. [740738]

WRITTEN NOTIFICATION: Individualized medical directives and orders

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 87
Individualized medical directives and orders
s. 87. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs.

The licensee has failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs.

Rationale and Summary
On a specified date in December 2023, a resident was experiencing a health concern. A Registered staff performed a procedure on the resident.

The home's Continence Care and Bowel Management program included a procedure outline, which required Registered Staff to obtain an order from the physician. The resident's clinical record did not include an order for the procedure. The interim DOC confirmed that there was neither an order nor a medical directive for the procedure.

Failure to ensure that an order was obtained prior to a procedure put a resident at risk of harm.

Sources: A resident's clinical record, the home's Continence Care and Bowel Management Program, dated April 7, 2022, interview with interim DOC. [740738]

WRITTEN NOTIFICATION: Resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
On a specified date in December 2023, a resident was experiencing a health concern. A Registered staff performed a procedure on the resident. There was no documentation within the resident's records to identify that this had occurred, what the results were, or how the resident was during and after the procedure.

Failure to ensure that a procedure was documented posed a risk of staff not being updated of the resident's provisions of care provided.

Sources: A resident's progress notes, interview with Interim DOC. [740738]

COMPLIANCE ORDER CO #001 Hiring staff, accepting volunteers

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 252 (3)
Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and

be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Audit all current Registered Staff Human Resources (HR) files to ensure they contain a valid police record check (vulnerable sector check), including agency Registered Staff.
- Retain records of the audit conducted, including any corrective action required and taken.

Grounds
The licensee has failed to ensure that a Registered staff had a vulnerable sector check prior to their hire.

Rationale and Summary
A Registered staff was involved in an incident on a specified date in December 2023. During the inspection, Inspector (740738) requested a copy of the staff's police record check (vulnerable sector check). The interim DOC stated that the home completed these checks prior to hire and that they were unable to locate one for this Registered staff. The interim Executive Director (ED) was also unable to locate it.

Failure to ensure that a Registered staff had a vulnerable sector check prior to their hire put residents at risk of harm.

Sources: Interview with interim DOC and ED, missing employee records. [740738]
This order must be complied with by August 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.