Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: August 2, 2023	
Inspection Number: 2023-1233-0003	
Inspection Type: Critical Incident System	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Dundurn Place Care Centre, Hamilton	
Lead Inspector Brittany Wood (000763)	**Inspector Digital Signature**
Additional Inspector(s) Stephanie Smith (740738)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
July 25-28, 2023

The following intake was inspected:
Intake: #00092345/CI#2739-000010-23 related to a fall with injury.

The following intake(s) were completed in this inspection:
Intake: #00085375/CI#2739-000003-23; Intake: #00091480/CI#2739-000006-23 and Intake: #00092083/CI#2739-000008-23 were related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

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)

The licensee 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
A resident had a fall resulting in an injury. The resident was identified in their plan of care to have instructions to decrease their risk of injury related to falls. At the time of the fall the resident did not have their falls interventions in place according to the plan of care. The Long Term Care Home's (LTCH) investigation notes indicated that staff removed the fall risk intervention to provide care and did not reapply the intervention afterward.

The DOC confirmed the resident did not have their falls interventions in place prior to the fall and that the resident should have.

Failure to ensure that the care set out in the plan of care regarding the resident's safety was provided to the resident, led to increased risk of injury.

Sources: Investigation notes, progress notes and interview with DOC

[000763]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

The licensee has failed to comply with their falls prevention and management program, its relevant policies, procedures, and protocols.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there was a written

description of the falls program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required and must be complied with.

Specifically, staff did not comply with the policy “Post Fall Assessment Policy”, dated May 2023.

Rationale and Summary
A resident had a fall that resulted in a hospital transfer. A registered staff did not notify the physician after the resident was transferred to the hospital. The registered staff left a note in the physician communication's book. The DOC confirmed that staff should have notified the physician immediately and that the investigation notes indicated the physician was unaware of the resident status.

The LTCH's fall prevention and management policy stated staff are to notify the physician immediately after with the assessment results.

Failure to notify the physician immediately regarding the resident's status led to the physician being unaware of the residents changes in care.

Sources: Post Fall Assessment Policy revised May 2023 and interview with DOC

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WRITTEN NOTIFICATION: Bed Rails

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where bed rails are used, a resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Rationale and Summary
A resident's plan of care included an initial bed rail assessment that had indicated no use of bed rails. A registered staff acknowledged residents were to have an assessment completed prior to using bed rails on their bed. A registered staff confirmed that the resident did not have a current assessment in the Long Term Care Home (LTCH) online documentation system.

The LTCH's bed rail policy stated, residents were required to have an assessment completed prior to using bed rails. The resident bed was observed to have a bed rail on both sides of the bed. The resident's most recent bed safety assessment completed upon admission indicated no use of bed rails.

Failure to ensure a resident was assessed and their bed system was evaluated put the resident's safety at risk.

Sources: The LTCH's bed rail policy, a resident's clinical record, and interview with registered staff.

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WRITTEN NOTIFICATION: General Requirements of a Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee failed to ensure that a written record relating to the falls prevention and included a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The home's program evaluation for Falls Prevention and Management for 2022 indicated the changes to the home's program but did not include dates the changes were implemented.

The Director of Care (DOC) acknowledged that the program evaluation did not include the dates the changes were implemented.

Sources: Fall prevention and management evaluation 2022 and interview with DOC

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