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

London District
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Original Public Report

Report Issue Date: October 12, 2023
Inspection Number: 2023-1084-0005
Inspection Type: Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Berkshire Care Centre, Windsor

Lead Inspector Stacey Sullo (000750)	**Inspector Digital Signature** Stacey Sullo Digitally signed by Stacey Sullo Date: 2023.10.12 15:04:27 -04'00'

Additional Inspector(s)
Adriana Congi (000751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 4, 5, 6, 2023

The following intake(s) were inspected:

- Intake: #00094298 and #00094360 were related to falls prevention and management

Inspection Manager Amie Gibbs-Ward was also present during this inspection

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that each resident's plan of care was reviewed and revised after reassessment.

On observation, the bedside transfer logo in the resident's room was not congruent with the care plan.

A revised care plan reflected the resident's transfer logo as observed in the resident's room.

Sources: Interviews with staff, and observations.

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Date Remedy Implemented: October 5, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 a personal assistant device (PASD) was provided to a resident as specified in the plan of care.

Rationale and Summary
Review of a resident's care plan indicated that staff must ensure appropriate PASD's are in use, as a means of falls prevention, as this resident is at high risk for falls.

On observation of resident there was no PASD's used at the time.

In interviews with staff members, it was confirmed that PASD's should have been used and available on the unit.

Failure to use the PASD's placed the resident at risk of injury.

Sources: The resident's care plan, observations of resident, and interviews with staff.

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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
Resident Care Plan identified resident as a high falls risk, and listed Personal Assistive Devices (PASD) that staff were to use.

During several observations of a resident the PASD's outlined in the care plan was not consistently being used by the staff as directed in the plan of care.

Interviews with the staff confirmed, staff was to be using the PASD's at all times.

Failing to provide the resident with all fall's interventions listed in the care plan put the resident's safety at risk.

Sources: Record Review of Care Plan, observations of resident, and interviews with staff.

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WRITTEN NOTIFICATION: Plan of care- Integration of assessments

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other, in the development and implementation of the plan of care so that the

different aspects of care were integrated and were consistent with and complement each other.

Rationale and Summary
During an observation of resident, staff were observed entering a resident's room with equipment not listed in the plan of care or as the bedside logo listed for transfers.

Interviews with staff, confirmed the care plan and bedside transfer logo were not congruent with what was being used by staff.

Failing to follow the falls process of notifying team members of resident's transfer changes put the resident’s safety at risk.

Sources: Review of Care Plan, observations of resident, and interviews with resident and staff members.

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