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: November 9, 2023
Inspection Number: 2023-1084-0006
Inspection Type: Complaint Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Berkshire Care Centre, Windsor

Lead Inspector	**Inspector Digital Signature**
Stacey Sullo (000750)	Stacey Sullo Digitally signed by Stacey Sullo Date: 2023.11.09 15:15:07 -05'00'

Additional Inspector(s) Adriana Congi (000751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30, 31, 2023 and November 1, 2, 6, 7, 8, 2023

The following intake(s) were inspected:

- Intake: #00095535 - 2541-000051-23: Resident to resident abuse.
- Intake: #00095840 - 2541-000053-23: Injury with unknown origin.
- Intake: #00096858 - IL-17455-LO/IL-17490-LO: Complaints regarding front entrance of building, and food temperature.
- Intake: #00099651 - 2541-000057-23: Outbreak

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Behaviours and Alterations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to comply with procedures and interventions developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among resident's.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies and protocols developed for resident safety were complied with.

Rationale and Summary
On August 25, 2023, an incident occurred between two residents. As per the home's policy, staff were required to complete documentation and assessments on residents involved in the incident.

In interviews with staff members, it was confirmed documentation and assessments had not been completed on residents involved in the incident.

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

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WRITTEN NOTIFICATION: Nutritional Care And Hydration Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to comply with the homes food temperature policy ensuring staff were taking temperatures of the food prior to being served, and after serving the meals.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the dining and snack service, and to ensure these policies and

protocols were complied with.

Rationale and Summary
In interviews with staff members, food temperatures were not taken before being served or after the meal delivery services consistently.

Sources: record review of food temperature log sheets, interviews with resident, dietary staff, and observations of meal delivery on multiple units.

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