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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date **July 4, 2022**

Inspection Number 2022_1061_0001

Inspection Type

☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Banwell Gardens Care Center, Windsor

Lead Inspector
Debbie Warpula #577

Debbie L Warpula
Digitally signed by Debbie L Warpula
Date: 2022.07.04 15:43:24 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9 to 13, and 16, 2022.

The following intake(s) were inspected:

- Intake #006146-22 related to a resident fall with fracture
- Intake #003636-22 related to a resident fallwith fracture
- Intake #002824-22 related to Follow up to Compliance Order (CO) #001 issued on February 22, 2022 under Inspection Report #2022_791739_0006 related to Ontario Regulation (O. Reg) r. 73 (1) 11 (Dining and Snack service) with a compliance due date of March 14,2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 73 (1) 11	2022_791739_0006	001	Debbie Warpula #577

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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 a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Rationale and Summary
A Critical Incident System (CI) report was received by the Director on a specified date, related to a resident's fall with an injury.

A record review of the resident's care plan indicated that staff were to have ensured that their assistive device was to be in a specific position and staff were to remind/encourage the resident to use it.

On two consecutive dates, Inspector #577 observed the resident and their assistive device was not in the specified position.

During an interview with the Director of Care (DOC), they indicated that the assistive device should not be included in the resident's care plan, as they would not know to use it. The DOC amended the care plan to indicate that the resident was unable to use their assistive device and staff were to ensure a specific intervention.

Date Remedy Implemented: May 16, 2022 [577]

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Impact or risk
There was no impact and low risk to the resident as they would not know how to use the assistive device and staff were doing frequent specified interventions.

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg 246/22 s. 115(5)3(v)

The licensee has failed to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

Summary and Rationale
Two CI reports were received by the Director related to two resident's who had falls with specific injuries.

During a review of the CI reports, Inspector #577 noted that neither reports were amended to include the date of when the resident's returned from receiving medical attention.

During an interview with the DOC, they confirmed with Inspector #577 that they had not documented any amendments to the CIS reports, and then updated the reports.

Date Remedy Implemented: May 12, 2022 [577]

Impact or risk
There was no impact and low risk to the residents as the late amendment did not affect the outcome for the residents.

WRITTEN NOTIFICATION: PLAN OF CARE

NC#003 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 specific interventions in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A CI report was received by the Director on a specified date, related to a resident's fall with a specific injury.

A record review of the resident's care plan indicated that staff were to have ensured that the resident had a specified intervention at all times to safeguard against injury, a particular apparatus was to be used for a specific intervention and their assistive device was to be in a specific position.

A review of the home's "Fall Prevention Program", reviewed May 2021, indicated that staff were to ensure that assistive devices were within reach and follow the preventative measures as per the residents' care plan.

Inspector #577 observed the resident on two consecutive days, to not have a specified intervention in place. On a specified date, Inspector observed two Personal Support Worker's (PSWs) provide a specific intervention without a particular apparatus. On another specified date, the inspector observed the resident to be asleep in bed and their assistive device was not in the specified position.

During an interview with a PSW, they stated that sometimes the resident has the specified intervention in place and that the intervention wasn't used on an identified date, as the apparatus was soiled. Additionally, they indicated that they had not used a particular apparatus for a specific intervention and the resident required a different intervention. When asked what the care plan indicated, they said they did not know.

During an interview with Fall's Lead Registered Nurse (RN), they indicated that the PSW was not following the resident's care plan when they failed to use the particular apparatus and not apply the specified intervention.

Not following the resident's specified interventions in the care plan put the resident at actual risk for further injury.

Sources: review of the resident's care plan, the home's "Fall Prevention Program" reviewed May 2021, "Interdisciplinary Care Plan" (RCS-C-15 reviewed April 22, 2021), observations of the resident, interviews with an RN and other staff.

WRITTEN NOTIFICATION: IPAC LEAD

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 23 (4)

Rationale and Summary
The licensee has failed to ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

During an interview with the DOC they advised Inspector #577 that the home has been without an infection prevention and control lead since a specified date, and they were considered that lead until they fill the position.

There was actual risk of harm in the home by not having a dedicated infection control lead as a PSW was observed exiting a resident room on specific precautions not wearing Personal Protective Equipment (PPE) after providing care; two PSWs were observed entering a resident room on specific precautions to provide care, not wearing PPE; and another PSW was observed exiting a resident room on specific precautions not wearing PPE after providing care; additionally, PPE was not available at point of care for a specific number of resident rooms on specific precautions, which put residents and staff at risk of potentially spreading healthcare associated infections.

Sources: interview with the Director of Care.

COMPLIANCE ORDER #001 PLAN OF CARE

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6(4)a

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6. (4) a

The licensee shall:

A) Notify a specific resident's physician immediately after a fall and when the resident has a change in condition

B) Ensure when the resident has a change in condition and they require transfer to hospital, that the resident is transferred to hospital in a timely manner.

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Grounds

The licensee failed to ensure that staff and others involved in the different aspects of care of a resident, collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with, and complemented each other.

A CI report was received by the Director on a specified date, related to a resident's fall. The report indicated that the resident had two falls on a specified date; the physician was notified of the fall on an identified date, and a medical intervention was ordered. The intervention was done at the home on an identified date, which confirmed a specific injury and the resident required additional medical attention.

A review of the home's "Fall Prevention Program", reviewed May 2021, indicated that as part of their post fall assessment, staff were to immediately notify the physician after a fall.

A record review of the resident's progress notes revealed the following:

On an identified date, the resident was walking fast with their ambulatory aid in the hallway; a PSW witnessed the resident fall; on assessment there were no issues noted; a specified time later, the resident was found in a particular position in a particular area; it was their second fall that happened on that shift; there were no new issues noted; and the resident would be assessed by the physician on their next visit to home.

Two days later, staff and the resident's family were reporting a change in condition and a specific impairment. The family requested a medical intervention; the physician was called and the intervention was ordered.

Four days later, the medical intervention was completed and indicated a specific injury and the resident required additional medical attention.

During an interview with an RN, they advised that when the resident had a change in condition, the physician should have been called and updated and the resident should have received additional medical attention.

During an interview with the Nurse Practitioner (NP), they advised that it was the home's practice to have the medical intervention completed in the home as opposed to transporting the residents to another health facility. They further indicated that when the resident had a change in condition, they or the physician should have been notified.

There was actual risk of harm to the resident, as staff did not collaborate on their assessments of the resident, and the physician or NP was not called when there was a delay in the medical intervention for five days and the resident had a change in condition.

Sources: review of the resident's care plan and progress notes, post fall assessments, a specific routine, fall assessments, physiotherapy assessments, the home's "Fall Prevention Program" reviewed May 2021, "Interdisciplinary Care Plan" (RCS-C-15, reviewed April 22, 2021), observations of the resident, and interviews with the Nurse Practitioner (NP) and other staff.

This order must be complied with by
June 16, 2022

COMPLIANCE ORDER #002 INFECTION PREVENTION AND CONTROL

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102(8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

The Licensee has failed to comply with s. 102(8)

The licensee shall:

A) DOC or designate will conduct an audit of all rooms on specific precautions and ensure there is required equipment at point of care, as directed by the home's Public Health Unit (PHU). The DOC or designate will ensure that the required equipment is maintained.

B) Ensure four identified PSWs wear appropriate PPE when providing care to residents on specific precautions.

C) Ensure an identified RN, and four identified PSWs receive re-training on PPE requirements for residents on specific precautions.

D) Maintain records of the training provided including, dates, times, attendees, trainers and materials taught.

Grounds

The licensee has failed to ensure that the infection prevention and control program required under subsection 23 (1) of the Act complies with the requirements of this section: all staff participate in the implementation of the infection prevention and control program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

Review of the home's policy "Additional Precautions – IFC-F-05" revised April 26, 2021, indicated that Additional Precautions were practices put in place on top of Routine Practices to prevent the spread of infection and to elevate precautions taken when it was identified that there was an increased risk of infection. When Additional Precautions were implemented, staff must ensure that there was appropriate signage specifying the precautions needed, appropriate personal protective equipment (PPE) was readily available, necessary equipment dedicated to the resident, and additional cleaning measures were implemented. For Contact Isolation, staff were to implement a "Contact Precautions" sign on the resident's door and PPE should be kept outside the room in an accessible area/cart, as to not contaminate clean equipment.

During a record review of the home's specified precaution list, Inspector #577 determined that the home had a specific number of residents on specific precautions for specified medical conditions. The inspector confirmed this with the DOC.

a) On an identified date, Inspector #577 observed a PSW exit a resident's room after providing care, not wearing PPE. Inspector #577 observed a specific precautions sign on the door. Inspector #577 noted through record review, that the resident was on specific precautions for a medical condition. The PSW told the Inspector that the resident wasn't on specific precautions and the signage was inaccurate.

On another identified date, Inspector #577 observed two PSWs enter a resident's room with a specified medical condition, not wearing PPE. Inspector #577 observed a specific precautions sign on the door. The inspector noted through record review that the resident was on specific precautions for a medical condition. Both PSWs confirmed they performed a specified intervention with the resident, had not donned PPE, and did not know why the resident was on specific precautions. One of the PSWs stated that they should have donned PPE.

On that same date, Inspector #577 observed a PSW exit a resident's room with a mobility apparatus, not wearing PPE. Inspector #577 observed a specific precautions sign on the door. The inspector verified records and confirmed that the resident was on isolation for specified medical condition. The PSW told the inspector that they were assisting their co-worker transfer the resident into their bed. The PSW stated that they were not aware of the resident being on isolation and indicated that because the resident goes to the dining room, they didn't think they were on isolation.

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In an interview with an RN, they advised that they were not sure about the PPE requirements for residents with specified medical conditions.

In an interview with an RN, they advised that staff were required to donn PPE before entering the room of a resident who was on specific precautions for specified medical conditions, and that the PPE should be outside the residents' room.

b) During observations on a specified date, Inspector #577 noted a specific number of resident rooms on specific precautions without PPE at point of care, and not in an accessible area by the resident rooms.

During an interview with the DOC, together with the inspector, toured the unit and identified rooms that were on specific precautions for specified medical conditions, and did not have PPE outside their rooms, at point of care. The DOC advised that they had direction from the Windsor/Essex health unit, that it was acceptable to space the bins through-out the hallways.

Windsor-Essex County Public Health Inspector #120 advised the inspector that PPE at the resident's doorway for specific precautions was best practice.

The Windsor-Essex County IPAC Hub Lead-Manager advised the inspector specific precautions (PPE) for all interactions that may involve contact with residents with specific medical conditions and their environment. Donning PPE upon room entry and properly discarding before exiting the resident's room was key Infection Prevention and Control (IPAC) measures to contain pathogens. PPE had to be readily available at the point of care and must be kept safe and protected from potential contamination.

Staff not implementing the home's IPAC program by not wearing appropriate PPE and PPE unavailable at point of care, put residents and staff at risk of potentially spreading healthcare associated infections.

Sources: IPAC tour of the home, the home's Antibiotic Resistant Organisms (ARO) list, the home's policy "Additional Precautions" (IFC-F-05 revised April 26, 2021), IPAC observations of the home, email from Windsor-Essex County IPAC Hub Lead-Manager and Windsor-Essex County Public Health Inspector, and interviews with the DOC and other staff.

This order must be complied with by June 30, 2022

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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day ofmailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second businessday 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respectto 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:

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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
email: 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.