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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 31, 2023

Inspection Number: 2023-1061-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Banwell Gardens Care Centre, Windsor

Lead Inspector	**Inspector Digital Signature**
Julie DAlessandro (739)	Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.04.03 09:58:58 -04'00'

Additional Inspector(s)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29 and 30, 2023.

The following intake(s) were inspected:

- Intake: #00017243- Complaint related to alleged resident to resident abuse
- Intake: #00017805/ CI #2263-000001-23 related to injury of unknown cause
- Intake: #00018749 -Follow-up Intake CO #001 from Inspection 2022-1061-0002 relating to FLTCA, 2021, s. 19 (2) (a) relating to cleanliness of all shower and tub rooms, CDD March 9, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1061-0002 related to FLTCA, 2021, s. 19 (2) (a) inspected by Cassandra Taylor (725)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (1) (a)

The licensee failed to ensure that there was a written plan of care that set out the planned care for a resident.

Rationale and Summary
A progress note indicated that there had been an incident between two residents. Another progress note indicated that the incident had been reviewed and two separate interventions were put in place for the safety of one of the residents.

An observation of the resident room was completed and both interventions were in place.

Record review of the plan of care for the resident did not include the two interventions.

During interviews with three staff members, they all stated that the resident had the two interventions in place and acknowledged that they were not in the plan of care.

Sources: progress notes and plan of care, as well as observation of a resident room and staff interviews. [739]

WRITTEN NOTIFICATION: Reporting to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an incident of suspected abuse was immediately reported to the Director.

Rationale and Summary
A progress note indicated that there had been an incident between two residents. Another progress note indicated that one of the residents was on increased monitoring for safety.

A review of the Critical Incident System, used for reporting, was completed and did not include a critical incident report for the incident between the two residents.

During an interview with a staff member of the home, they acknowledged that the incident should have been reported to the Director, as it was suspected abuse, and was not.

Sources: progress notes, review of the CIS, and staff interview.
[739]