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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date September 20, 2022
Inspection Number 2022_1050_0002
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
Cooksville Care Centre, Mississauga

Lead Inspector
Daniela Lupu (758)

Inspector Digital Signature
Daniela Lupu
Digitally signed by Daniela Lupu
Date: 2022.09.23 17:51:21 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 29-31, September 1, 6, and 7, 2022.

The following intake(s) were inspected:

- Log # 014988-22 (Complaint) related to staffing shortage and resident care

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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Non-compliance with: O. Reg. 246/22 s. 79 (2)

The licensee has failed to ensure that seven residents who required assistance with eating and drinking were served a meal until staff were available to assist them.

Rationale and Summary

A. Five residents were at nutritional risk and needed assistance from one staff member with their meals.

On one occasion, during the lunch meal service, four residents were provided a meal when a staff was not available to provide them with assistance. Three residents did not receive assistance with their meal until 30 minutes after their meal was served. One resident did not receive assistance to drink or eat until 20 minutes after their meal was served.

On a second occasion, during the lunch meal service on the same resident home area (RHA) , two residents received their meal when no staff was available to provide them with assistance. One resident did not receive assistance with their drinks until 15 minutes after their drinks were served. A different resident did not receive assistance with their meal until 20 minutes after their soup was served.

On a third occasion, during the lunch meal service on the same RHA, one resident did not receive assistance to drink or eat until 14 minutes after their meal was served. A different resident was not encouraged or assisted to drink until 22 minutes after their drinks were served.

The home's Dietary Manager, the Food Supervisor and the Director of care (DOC) said residents who required assistance with eating or drinking should not be served drinks or food until a staff member was available to assist them.

B. Two residents were at nutritional risk and needed assistance from one staff member with their meals.

On one occasion, during the breakfast room service, two residents were observed with their breakfast meal tray on the bedside table when no staff was available to assist them.

Approximately 10 minutes after the inspector's observation, both residents were assisted with their meals. The Registered Practical Nurse (RPN) who assisted one of the residents said they were not aware when the breakfast trays were provided to the residents.

The home's Dietary Manager and the DOC said room service should be provided after the dining room service was finished and when staff were available to provide assistance and monitor the residents.

Staff not providing residents with the required assistance when their meals were served posed a potential risk that their meals became cold.

Sources: seven residents' care plans, documentation survey report v2 - August 2022, the home's Pleasurable dining policy, and interviews with 2 RPNs, one RN, Dietary Manager, Food Supervisor, and DOC.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

A. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 indicated the licensee shall make PPE available and accessible to staff and residents, including having a PPE supply in place and ensuring adequate access to PPE for Additional Precautions.

The home's Droplet and Contact Precautions policy documented that gowns, gloves, surgical masks, and eye protection should be available at the point of care when droplet and contact precautions were in place. Based on the point of care risk assessment, N95 respirators should also be available at the point of care.

At the time of these observations, two residents were on Droplet and Contact precautions and their PCR test results were pending.

On one occasion, the PPE station adjacent to these residents' room had no eye protection, surgical masks and N95 respirators.

The home's IPAC Lead said that eye protection, surgical masks and N95 respirators should have been available at the point of care when droplet and contact precautions were in place.

Sources: observations of two residents' room, IPAC Standard (April 2022), the home's Droplet and Contact policy and interviews with one RPN, one RN, and the home's IPAC Lead and the DOC.
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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure that the home carried out the policy directive for PPE requirements when interacting with suspected cases of COVID-19.

Rationale and Summary

In accordance with the Minister's Directive, COVID-19 response measures for long-term care homes, effective April 27, 2022, issued under the Fixing Long-Term Care Act, 2021, the licensee was required to ensure that personal protective equipment requirements were followed as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units and Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities**.**

The Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, version 1.0, June 10, 2022, requires that all health care workers providing direct care to or interacting with, a suspect or confirmed case of COVID-19 wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator or approved equivalent.

At the time of these observations, a resident had symptoms compatible with COVID-19 and was placed on Droplet and Contact precautions. Their PCR test results were pending.

Public Health Ontario (PHO) droplet and contact precautions signage was posted on the resident's room door. The signage documented that mask, eye protection, gown and gloves should be worn when being within two meters of the resident.

On one occasion, a RPN entered in this resident's room to administer them medications. The RPN did not wear eye protection and an N95 respirator prior to entering the resident's room and did not change their mask before exiting the resident's room.

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PHO How to Remove Personal Protective Equipment signage posted in the resident's bathroom, directed staff to remove eye protection and discard mask or N95 respirator prior to exiting the resident's room.

On one occasion, a PSW did not wear an N95 respirator prior to entering in the same resident's room to assist them with their meal. Additionally, the PSW did not change their mask upon exiting the resident's room.

The home's IPAC Lead said staff should have worn N95 respirators and eye protection prior to interacting and being within two meters of a resident suspected of COVID-19. They also said the N95 respirator should have been changed to a surgical mask as part of PPE doffing, upon exiting this resident's room.

By not wearing the required N95 respirators when providing care or interacting with suspected cases of COVID-19 there was a potential risk of spreading COVID-19 to other residents, staff and visitors**.**

Sources: observations of two residents' rooms, a resident's progress notes**,** PHO How to Remove Personal Protective Equipment signage, the Minister's Directive, COVID-19 response measures for long-term care homes, effective April 27, 2022, the Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, (June 10, 2022), and interviews with a RPN and the home's IPAC Lead.

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