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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
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Amended Public Report (A1)

Report Issue Date: February 28, 2023	
Inspection Number: 2023-1050-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Cooksville Care Centre, Mississauga	
Inspector who Amended Janet Groux (606)	**Inspector who Amended Digital Signature** Janet Groux Digitally signed by Janet Groux Date: 2023.03.01 07:44:10 -05'00'

INSPECTION SUMMARY

This licensee inspection report has been revised to reflect the correct month of inspection. The Complaint and CIS inspection #2023-1050-0003 was completed on January 13,17-20, and 23-25, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 13, 17-20, 23-25, 2023.

The following intake(s) were inspected:

- Intake #00003816 regarding the home's Responsive Behaviour Management Program.
- Intakes #00008004, #00008916, and #00017013 regarding the home's Falls Prevention and Management Program.
- Intakes #00008772 and #00014973 regarding residents with injuries of unknown cause.
- Intake #00017847 regarding the home's Continence Care Program, and Reporting of Concerns.

1.

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

Infection Prevention and Control
Continence Care
Falls Prevention and Management
Responsive Behaviours
Resident Care and Support Services
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements

NC #1 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53(1)4.

a) The licensee has failed to ensure a pain assessment was completed for a resident.

In accordance with O. Reg 246/22 s. 11(1)(b) that the licensee shall ensure their pain program includes a process to identify and manage pain.

Specifically, the licensee did not comply with the home's Pain Management Program, which directed registered staff to complete a pain assessment when a Personal Worker (PSW) reported to them that a resident was having pain.

Rationale and Summary:

A resident was transferred to the hospital and was diagnosed with a serious injury of an unknown cause.

A Registered Practical Nurse (RPN) said staff informed them the resident was observed with pain during care. The RPN acknowledged they did not complete a pain assessment for the resident.

Failing to assess the resident's pain delayed the resident from receiving immediate treatment and care to manage their pain and may have caused the resident further discomfort and unrelieved pain.

Sources: a critical incident report, a resident's progress notes, SBAR Communication Form (Situation-Background-Assessment-Recommendation), the home's Pain Management Program, and interviews with staff. [606]

b) The licensee has failed to ensure that a resident's pain was reported to the registered staff.

In accordance with O. Reg 246/22 s. 11(1)(b) that the licensee shall ensure their pain program includes a process to identify and manage pain.

Specifically, the licensee did not comply with the home's Pain Management Program, which directed PSWs to report to the registered staff when they had identified a resident with pain.

Rationale and Summary:

A resident was transferred to the hospital and sustained a serious injury of an unknown cause.

Two PSWs said the resident complained of pain but did not report the resident's pain to the registered staff.

Failing to report the pain delayed the resident from receiving immediate treatment and care to manage their pain and may have caused the resident further discomfort and unrelieved pain.

Sources: a CI report, a resident's progress notes, the home's Pain Management Program, and interviews with staff.[606]

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