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

Hamilton District
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Original Public Report

Report Issue Date: June 16, 2023	
Inspection Number: 2023-1050-0004	
Inspection Type: Critical Incident System	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Cooksville Care Centre, Mississauga	
Lead Inspector Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2023.07.06 14:30:09 -04'00'
Additional Inspector(s) Stephany Kulis (000766) Dusty Stevenson (740739)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 11, 12, 15-17,19, 23-25, 2023

The following intake(s) were inspected:

- Intake: #00022475 – CI #2124-000008-23 related falls prevention program.
- Intake: #00084690 – CI #2124-000012-23 Improper care of a residents.
- Intake: #00085252 -CI #2124-000014-23 - related to related falls prevention program .
- Intake: #00087347 – CI #2124-000015-23 - Physical abuse of resident by another resident

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

Skin and Wound Prevention and Management

Medication Management

Infection Prevention and Control

Prevention of Abuse and Neglect

Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure the Substitute Decision Maker (SDM) was notified when the fall interventions for a resident were discontinued.

Rationale and Summary
A resident had a fall prevention intervention in their plan of care. Record review indicated that the fall interventions had been discontinued without SDM collaboration. Registered Nurse(RN) indicated that they did not call the SDM for consent for discontinuing interventions.

As per the Fall Prevention Program, members of the interdisciplinary team, in collaboration with the resident and family ensure effective measures are in place to reduce and/or minimize the risk of falling.

As a result of not involving the resident's SDM for discontinuing resident's fall interventions, the SDM and resident did not have opportunity to have input into the resident's plan of care.

Sources
Falls Prevention Program; Interview with RN, care plan revision on March 16, 2023; observations [000766]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the post-operative interventions set out in a resident's plan of care was

provided as specified in the plan.

Rationale and Summary
Resident underwent a surgical repair. Post-operatively, resident was required to keep their limbs supported with external support and not to raise their limbs from a certain level.
On three occasions, inspector noted that resident's limbs were not supported and raised above the recommended level.

As a result of not following post-operative recommendations, there was risk to the healing of the surgically repaired area.

Sources
Interviews with Director of Care (DOC) and Physiotherapist (PT) plan of care; observations.
[000766]

WRITTEN NOTIFICATION: Protection from certain restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

The licensee has failed to ensure staff do not use resident wheelchair as a restraint for the convenience of the staff.

Rationale and Summary
Resident was observed sitting in the doorway of their room tilted back in their wheelchair. A Personal Support worker (PSW) was caring for the resident at the time and was asked if tilting the wheelchair was part of resident's care plan. PSW stated it was not part of the resident care plan and that the wheelchair was tilted to prevent the resident from slipping. Later that day, RN stated the resident should be seated in an upright position- a tilted wheelchair would be considered a restraint, and would promptly go assess the issue.

As a result, the wheelchair being tilted restrained the movement of resident .

Sources
Interviews with RN and PSW; resident's Medical Director (MD) orders and care plan; observations of resident .
[000766]

WRITTEN NOTIFICATION: Binding on licensees

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure visitor's in the home adhere to the Minister's Directive: COVID-19 response measures for long-term care homes effective March, 31, 2023, with regards to masking requirements in common areas.

Rationale and Summary
In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes , when visitors are not in a one-on-one setting with a resident, they are required to be masked. In May 2023, an unmasked visitor was observed eating a meal with a resident during lunch time in the dining room. The home's Infection Prevention and Control (IPAC) lead said visitors are required to mask upon entering the home and they cannot remove their mask and eat with the residents.

As a result, there was potential for the spread of infectious disease when an unmasked visitor was within two meters of multiple residents.

Sources
Interview with IPAC lead and observations.
[000766]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that resident was provided with immediate treatment and interventions to reduce or relieve pain and prevent an infection.

Resident had surgical wound on their limb, progress notes specified that resident was experiencing pain and swelling on their limb. A scheduled pain medication was administered for pain management for three days in March 2023.

Resident continued to experience excruciating pain and had worsening edema on their limb; a medical test was ordered by the physician.

There was no assessment or change in the treatment provided prior to the medical test. Medication was adjusted by Medical Director after the medical test and ordered by the MD to be administered on a schedule basis.

Registered staff verified that there was a delay in the treatment and resident's pain and swelling concerns were not addressed immediately.

Failure to provide immediate treatment and effective pain management, resulted in harm to the resident with delayed treatment of their medical condition.

Sources
Homes investigation report March 22,2023, Resident's progress notes, Interviews with PSW, RPN and RN . [741104]

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee failed to ensure staff used appropriate communication and assessment methods to assess resident pain after the fall.

Rationale and Summary
Resident was cognitively impaired and there was language barrier between resident and staff. In March 2023, a registered staff conducted a post-fall assessment on a resident where facial grimacing was noted, however, resident pain score was nil on the assessment. A day after the assessment, resident's family member reported to the home that resident continues to have pain post-fall. In an interview, the staff indicated they did not use the proper communication tools to assess pain when the resident was wincing. The DOC stated there was a lack of knowledge amongst staff and they had observed staff using a numeric pain scale for residents with advanced dementia in the past as opposed to using the appropriate pain communication tool .

As a result, the staff did not follow appropriate communication and assessment techniques to determine when the resident was experiencing pain.

Sources
Interviews with DOC and PT ; CI Report #2124-000014-23; residents record.
[000766]

WRITTEN NOTIFICATION: Pain management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure when resident's pain was not relieved by initial interventions a pain assessment tool was completed.

Rationale and Summary
Staff failed to complete a new pain assessment when PRN (as needed) medications were ineffective. Resident received PRN Tylenol two days in March 2023. Four days after, the resident's family member called the home with concerns of what is being done about the resident's pain. A staff member had assessed the resident's pain on the same day the family member called. No new pain assessment was completed when initial interventions were ineffective.

DOC stated that there should have been a pain assessment completed when family brought forth concerns, and MD to be notified if there was a need for reassessment.

As a result, the resident was not properly assessed and evaluated pain when initial interventions did not provide pain relief.

Sources
CI Report #2124-000014-23; progress notes; Interview with DOC.
[000766]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee failed to ensure that when a resident's fall resulted in a significant change, the Director was informed of the incident within three business days after the incident.

Rationale and Summary
Resident fell on March 24, 2023, and the CI submission date was April 6, 2023. On March 31, 2023, the registered staff determined that the resident required a mechanical lift. The DOC confirmed that when

the resident began to require a Hoyer lift on March 31, 2023, it was considered a significant change.

Sources
CI Report #2124-000014-23; PT, progress notes; Interviews with DOC.
[000766]