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: September 10, 2024
Inspection Number: 2024-1050-0002
Inspection Type: Complaint Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Cooksville Care Centre, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 13-16 & 19-23, 2024

The following intake(s) were inspected:

- Intake: #00116033- complaint related to resident care and support services, prevention of abuse and neglect and housekeeping, laundry and maintenance services.
- Intake: #00117205 - critical incident (CI) related to falls prevention and management.
- Intake: #00118533 - CI related to prevention of abuse and neglect.
- Intake: #00119268 - complaint related to prevention of abuse and neglect.
- Intake: #00121643 - CI related to prevention of abuse and neglect.
- Intake: #00121885 - CI related to resident care and support services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
On a specified day, the Director of Care (DOC) was notified that a resident had a new skin issue. The resident's care plan specified that they required two people for care. The investigation determined that a staff member provided care to the resident without having a second staff member with them.

The DOC confirmed that the staff member provided care without having a second staff member present.

Failure to ensure that care set out in the plan of care was provided as specified, put the resident at risk of injury.

Sources: Investigation package, resident's clinical records, DOC interview.

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure that the outcomes of the care set out in the plan of care for a resident were documented.

Rationale and Summary
A staff member was directed by a physician to add an intervention with other specified orders, including documentation.

The resident's clinical record review showed that there were several days when the intervention was not completed three times a day, as ordered.

The DOC confirmed that the intervention was not documented as ordered and verified that registered staff were expected to document the value for the ordered intervention.

Failure to document the outcomes of care set out in the plan of care for the resident may have resulted in a delay in transferring the resident to the hospital.

Sources: Resident's clinical records, home's investigation notes; interviews with registered staff, DOC and other staff.