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**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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# Original Public Report

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| **Report Issue Date:** October 11, 2023 | |
| **Inspection Number:** 2023-1233-0004 | |
| **Inspection Type:**<br>Proactive Compliance Inspection | |
| **Licensee:** Rykka Care Centres LP | |
| **Long Term Care Home and City:** Dundurn Place Care Centre, Hamilton | |
| **Lead Inspector**<br>Adiilah Heenaye (740741) | **Inspector Digital Signature**<br>Adiilah H Heenaye Sumser<br>Digitally signed by Adiilah H Heenaye Sumser<br>Date: 2023.10.13 14:48:43 -04'00' |
| **Additional Inspector(s)**<br>Lisa Vink (168) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 18-20, 22, 25-27, 2023.

The following intake was inspected:

- Intake: #00096925 -Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 19 (1) (c)

The licensee failed to ensure that the home and equipment was maintained in a good state of repair.

**Rationale and Summary**

A resident's bathroom sink was noted to have a brown stain in the basin and a tub room chair in one of the home' spa had a tear in the seat cushion with exposed "padding".

The bathroom sink and the seat cushion for the tub lift was observed to be replaced after three days. Failure to maintain the tub chair seat cushion in a good state of repair increased the possibility that the seat was not adequately cleaned between residents/usage.

**Sources**: Observations of resident bathroom and spa and interviews with the Environmental Services Supervisor and Director of Care. [168]

Date Remedy Implemented: September 22, 2023

**NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)**
O. Reg. 246/22, s. 19

The licensee failed to ensure that every window that opened to the outdoors and was accessible to residents had a screen.

**Rationale and Summary**

Two windows in a resident's bedroom was not equipped with screens.
The Environmental Services Supervisor (ESS) indicated that the screens were removed to accommodate air conditioning units which were since removed.

The screens were noted to be in place three days later.

Failure to ensure that windows were equipped with screens had the potential for insects to enter the home when the windows were opened.

**Sources**: Observations of a resident's room and interview with the ESS. [168]

Date Remedy Implemented: September 22, 2023

**NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident regarding sleep and rest routines.

**Rationale and Summary**

A resident voiced concerns regarding the time they were awoken by staff in the morning. The resident's admission care conference indicated their usual wake time. The plan of care included a document referred to as the care plan. The care plan did not include a focus statement regarding sleep patterns or the residents' desired wake time.

It was then noted that sleep patterns and the desired wake time was added to the resident's plan.

**Sources:** Review of plan of care and interview with a resident and interview with registered staff and other staff. [168]

Date Remedy Implemented: September 26, 2023

**NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that a resident's written plan of care was based on an assessment.

**Rationale and Summary**

The inspector observed a resident having their meal during lunchtime. The feeding assistance provided to the resident was different from what was identified in the dietary care plan.

A registered staff stated that the resident's feeding status had changed.

The registered staff updated the resident's care plan the same day under activities of daily living, however, the dietary care plan was not updated.

The registered dietician assessed the resident after a week, and the dietary care plan was updated reflecting the resident's feeding status.

**Sources:** A resident's clinical record; Observation of a resident at mealtime; interview with registered staff. [740741]

Date Remedy Implemented: September 27, 2023

**NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised when their care needs changed or care set out in the plan was no longer necessary.

**Rationale and Summary**

The plan of care for a resident, included a document referred to as the care plan. This document identified that the resident's mobility, oral care needs and a falls intervention strategy.

The resident's mobility was observed, and it was different from the care plan and the falls intervention was not in place. A staff stated the resident's oral care routine, and it was different from what was identified in the resident's care plan. The staff also reported that the resident's mobility status had changed and that the identified falls intervention was no longer required.

Registered staff then revised the plan of care to be reflective of the current needs of the resident. Failure to revise the plan of care when the resident's care needs changed, or care was no longer required had the potential for staff to provide care not consistent with needs.

**Sources:** Plan of care and observations of a resident and interview with staff. [168]

Date Remedy Implemented: September 20, 2023

## WRITTEN NOTIFICATION: Transferring and positioning techniques

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a resident was transferred using safe transferring techniques.

**Rationale and Summary**

The plan of care for a resident related to transfer was identified in the care plan. A staff was observed transferring the resident not as per the resident's plan of care.

By the home not following the resident's plan of care related to transfers, put the resident at risk of harm.

**Sources:** Observation of a resident and staff; Interview with staff; review of the resident's care plan. [740741]

## WRITTEN NOTIFICATION: Infection and Prevention Control

**NC #007 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 Infection Prevention and Control (IPAC) Standard, April 2022, issued by the Director was complied with.

**Rationale and Summary**

A Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) (iii) related to routine practices was complied with for at a minimum use of administrative controls including but not limited to, comprehensive IPAC policies and procedures.

A staff was observed not cleaning a ceiling lift after resident use. The staff stated that the expectation was to clean the mechanical lift after every use using Oxivir wipes.

A review of the home's policy titled Cleaning of Medical/Personal care Equipment and Contact Surfaces did not provide instructions on how to clean a ceiling lift and the frequency for cleaning, but stated to use Virox wipes as a disinfectant. The IPAC lead confirmed that the home does not have policies and procedures related to cleaning of ceiling lifts.

Failure to have comprehensive policies and procedures related to the use of environmental controls for cleaning, provided unclear directions to staff and had the potential to increase the risk of spreading an infection.

**Sources:** Observations of a resident; interview with the IPAC lead and other staff. [740741]

B. Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) related to additional precautions was complied with for at a minimum point of care signage which indicated the enhanced IPAC control measures required.

The doors to three resident rooms had personal protective equipment in place; however, there was no signage to indicate the additional precautions required.
Signage, which identified that contact precautions were required, was hung on the bedroom doors of the residents, once the concern was brought to the attention of staff.

Failure to provide point of care signage when additional precautions were required had the potential for those who entered the room to not utilize the appropriate precautions and the risk of spreading an infection.

**Sources:** Observations of resident rooms, and interview with the IPAC lead and other staff. [168]

## WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 147 (2) (c)

The licensee failed to ensure that a written record was kept of the corrective action taken for every medication incident involving a resident.

**Rationale and Summary**

The home's medication incident reports was reviewed for the last quarter. There was no written record of the corrective actions made for each of the medication incidents in the last quarter. The DOC acknowledged that the home had no written records of the corrective actions taken.

There was risk to the resident by the home failing to have written records of the corrective actions taken after every medication incident involving a resident.

**Sources:** Interview with the DOC; Record review of the medication incident reports. [740741]

## WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)

The home has failed to ensure that a quarterly review was undertaken of all medication incidents that have occurred in the home since the time of the last review.

**Rationale and Summary**

The home did their quarterly medication management meeting, where a quarterly review of all medication incidents was completed. Four medication incidents were reviewed as per the home's meeting minutes. The pharmacy's documentation for the home's medication incidents in the last quarter was also provided for review. There were five medication incidents listed.

The DOC confirmed that one medication incident was missed in the home's last quarterly review of medication incidents. The DOC also stated that the home was aware of the medication incident, a medication incident report was made, an investigation was completed, corrective actions were taken, and the resident was monitored with no impact to the resident.

By missing a medication incident in their last quarterly review had the risk for the home to not reduce and prevent medication incidents and adverse drug reactions, not identify patterns of medication incidents, and not able to make any necessary changes and improvements.

**Sources:** Interview with the DOC; Review of the home's quarterly medication management system documentation and the home's pharmacy records for medication incidents in the home for the last quarter. [740741]