



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 23, 2015	2015_254610_0056	028503-15	Critical Incident System

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### **Licensee/Titulaire de permis**

RYKKA CARE CENTRES LP  
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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### **Long-Term Care Home/Foyer de soins de longue durée**

Berkshire Care Centre  
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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### **Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

NATALIE MORONEY (610)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 15, 16, 17, 2015**

**This Critical Incident inspection was completed related to responsive behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Clinical Coordinator Nurse, Social Worker, 3 Personal Support Workers, two Registered Practical Nurses.**

**During the course of this inspection the inspector conducted interviews, completed resident care observations, reviewed health care records and relevant policies and procedures**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**

**2 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**



1. The licensee had failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of Point Click Care (PCC) progress notes for resident # 004 showed that the resident had fallen.

A review of resident's post fall risk assessments showed that there was no post fall risk assessment using a clinically appropriate assessment tool after the fall.

The Clinical Educator confirmed the post fall assessment should be completed immediately after the fall.

The Administrator confirmed on December 15, 2015, that a post fall assessment should have been completed after the fall, and the Director of Care (DOC) confirmed on December 17, 2015, that a post fall assessment should have been completed using a clinically appropriate assessment tool. [s. 49. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**

**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**

**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**

**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A review of PCC documentation showed that Resident # 004 had behaviours.

An interview with the BSO Personal Support Worker on December 16, 2015, showed that they were using a purple dot system outside of resident rooms, the physician book, and the medication administration record that would indicate to staff residents that were high risk for physical altercations.

A review of the behavioural support binder on the second floor showed a document that explained the purple dot system and what it was for and when it would be used.

During an interview with the RPN on December 14, 2015, she confirmed they do not use the purple dot system on the medication administration record or resident rooms.

The Director of Care confirmed that resident # 004 should have had the purple dot system in place to indicate to staff the risk of aggression and that the strategies developed had not been implemented. [s. 53. (4) (b)]



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***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.***

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**Issued on this 14th day of January, 2016**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**