Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2019	2019_538144_0010	002913-19, 004599-19, 004604-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Berkshire Care Centre
350 Dougall Avenue WINDSOR ON N9A 4P4

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 6, 7, 8 and 11, 2019.

The following intakes were inspected with this inspection:
Log #002913-19, CIS #2541-000009-19 related to prevention of abuse, neglect and retaliation and skin and wound
Log #004604-19, CIS #2541-000013-19 related to care plans and plans of care
Log #004599-19, CIS #2541-000014-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with one resident, two family members, the Director of Care, Physiotherapist, three Registered Practical Nurses, four Personal Support Workers, the Environmental Services Manager and one maintenance personnel.

During the course of the inspection, five resident clinical records and one maintenance equipment order confirmation invoice reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs changed or the care set out in the plan was no longer necessary.

On one identified date, Registered Nurse (RN) #113 documented a health concern reported to them by one identified resident.

RN #113 reported the resident concern to RN #112 with the recommendation that the resident be monitored.

RN #112 documented that they had been informed of the residents' concern.

A visitor of the resident reported to RN #112 that the resident was not feeling well and that they would take the resident to the hospital.

Approximately eleven hours later, RN #105 contacted the hospital and was informed that the resident had been admitted.

The visitor of the resident reported to DOC #102 that they had expressed concern to RN #112 that the resident did not feel well and was advised that the resident was not ill.

The inspector was unable to locate a nursing assessment of resident #005's status prior to the resident leaving the home with their visitor.

Director of Care (DOC) #102 confirmed that prior to resident #005 leaving the home with their visitor, RN #112 did not complete a nursing assessment of the residents' status.

DOC #102 stated that an investigation was initiated and that RN #112 received disciplinary action.

DOC #102 stated that the expectation was that RN #112 should have completed a nursing assessment of resident #005 when their visitor reported that the resident wasn't feeling well. [s. 6. (10) (b)]

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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.