Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date September 30, 2022
Inspection Number 2022_1084_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Berkshire Care Centre Windsor

Lead Inspector
Terri Daly #115

Inspector Digital Signature
Terri Daly Digitally signed by Terri Daly Date: 2022.10.06 15:19:34 -04'00'

Additional Inspector(s)
Julie D'Alessandro #739
Andrea Dickenson #740895
Sheri Williams #741748

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 23-26 and 29, 30, 2022.

The following intake(s) were inspected:

- Intake #012994-22 CIS #2541-000036-22 related to falls prevention.
- Intake #013999-22 CIS #2541-000040-22 related to alleged resident to resident abuse.
- Intake #014933-22 CIS #2541-000045-22 related to a hypoglycemic event.
- Intake #015039-22 CIS #2541-000046-22 related to alleged neglect and improper/incompetent treatment of resident.
- Intake #014232-22 Complaint related to care and services.
- Intake #015142-22 Complaint related to skin and wound care.

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

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)

- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were *findings of non-compliance*.

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA s. 28 (1) 2

The licensee has failed to ensure that the alleged incident between two residents, was reported immediately to the Director.

Rationale and Summary
The Licensee submitted a Critical Incident System (CIS) Report on a specific date and time. The incident which caused injury, occurred the day prior to the date the CIS was reported.

An Assistant Director of Care (ADOC) acknowledged that this CIS Report was not reported to the Director immediately after the incident occurred. The Director of Care (DOC) verified that the CIS was not immediately reported to the Director.

Sources: A Critical Incident System (CIS) Report; Interviews with ADOC and DOC #110

[Inspector # 741748]

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 53 (1)1

The licensee has failed to comply with the procedure to follow the head injury routine (HIR) when a resident fell on a specific date.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee was required to ensure the falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Post Fall Assessment Policy (Revised Sep 2019, Reviewed Aug 2022), which was part of the licensee's Falls Prevention Program.

Rationale and Summary

A resident had an unwitnessed fall requiring specific monitoring post fall. The registered staff member on duty at the time of the fall initiated the Head Injury Routine (HIR) and monitored the resident through the Neurological Flow Sheet, with their last assessment completed prior to the end of their shift.

During a review of the homes' policy titled Fall Management. Post Fall Assessment Policy (Revised Sep 2019, Reviewed Aug 2022), number six under the Procedure section stated, "If there is evidence of a head injury, initiate the head injury routine immediately and follow the HIR protocol."

The Registered Practical Nurse that was responsible for this resident's care and was required to assess the resident at two different times according to the HIR. The RPN stated they had not assessed the resident during their shift and had only completed a progress note that the resident had been taken to the hospital.

Assistant Director of Care (ADOC)/Falls Lead acknowledged that the Neurological Flow Sheet had not been completed as required after this resident's fall.

Sources: A resident's Neurological Flow Sheet assessment record and progress notes; Fall Management Post Fall Assessment Policy (Revised Sep 2019, Reviewed Aug 2022); and interviews with ADOC/Falls Lead and an RPN.

[Inspector #740895]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity had been assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

During an interview, a Registered Nurse (RN)/Wound Care Nurse (WCN) confirmed that a resident's altered skin integrity had been deteriorating on a specific date. Nine days later, the

resident's scheduled weekly wound assessment was marked as refused with no additional attempts made to assess the wound or documentation completed regarding the resident's refusal.

Over two weeks after the wound had been identified as deteriorating, the resident was scheduled for a subsequent weekly wound assessment which was not completed that day or upon the inspector's review, on the next scheduled weekly assessment. The RN/WCN said the expectation was to complete weekly wound assessments within seven days, however this resident's altered skin integrity was not assessed during two scheduled assessments, leaving the wound unassessed for at least eighteen days.

Sources: A resident's Skin and Wound Evaluation assessments and progress notes; interview with the RN/WCN.

[Inspector #740895]