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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 9, 2023
Inspection Number: 2023-1084-0003
Inspection Type: Critical Incident System
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Berkshire Care Centre, Windsor

Lead Inspector	**Inspector Digital Signature**
Julie DAlessandro (739)	Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.03.09 14:36:35 -05'00'

Additional Inspector(s)
Cassandra Taylor (725)
Stacey Sullo (000750) attended this inspection during orientation

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 2, 3, 6, 7, and 8, 2023

The following intake(s) were inspected:
Intake: #00007842/CI #2541-000053-22 related to alleged neglect
Intake: #00020284/CI #2541-000007-23 related to alleged neglect
Intake: #00018852/CI #2541-000002-23 related to falls prevention and management
Intake: #00019577/CI #2541-000005-23 related to injury of unknown origin

During the course of this inspection an infection prevention and control inspection was also completed.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure that a resident's privacy was respected and promoted during their personal care.

Rationale and Summary

Two staff were observed, from the hallway, providing continence care and changing a resident's incontinence product. The two staff indicated they were aware of the resident's right to privacy and should have ensured the door was closed.

The home's policy titled, "Resident's Bill of Rights", outlined the Resident's Bill of Right's and indicated that the home was to ensure that the residents' rights were provided and respected.

The Director of Care (DOC) indicated that the expectation of all staff would have been to ensure the privacy curtain is pulled or the resident's door was closed when care was being provided.

Sources: Observation, the home's policy titled "Resident's Bill of Rights" and staff interviews with two staff and the DOC.
[725]

WRITTEN NOTIFICATION: Equipment Maintenance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c).

The licensee failed to ensure that a medical device was in a safe condition and in a good state of repair.

Section 19 (1) (c) of the Fixing Long-Term Care Act states that, every licensee of a long-term care home shall ensure that there is an organized program of maintenance services for the home.

Section (19) (2) (c) of the Fixing Long-Term Care Act states that, every licensee of a long-term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Section 11 (1)(b) of Ontario Regulation 246/22 states that, where the Act or this Regulation requires the licensee of a long-term care home to have any program, the licensee is required to ensure that the program is complied with.

Rationale and Summary
The home's program titled, "Medical devices/equipment calibration and preventative maintenance program", stated in part that, medical devices were to have been checked for proper functioning.

During an observation of the room where the medical device was kept, it was noted that the room did not have a checklist for the device to ensure that it had been functioning properly. An Assistant Director of Nursing (ADOC) was present at that time and inspector #739 had asked that they look for the checklist. The ADOC stated that the checklist should have been with the device, and they searched the room but it was not there.

During an interview with the DOC, they stated that the checklist for the device should have been completed by staff, however they were unable to locate the checklist. The DOC acknowledged that the checklist, to ensure that the device was functioning properly, should have been in place and was not.

Sources: The home's program titled, "Medical devices/equipment calibration and preventative maintenance program", last revised June 22, 2022, and staff interviews with an ADOC and the DOC [739]

WRITTEN NOTIFICATION: Use of Equipment in Accordance with Manufacturers' Instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26.

The licensee failed to ensure that a registered staff used a medical device in accordance with the manufacturers' instructions.

Rationale and Summary
A progress note indicated that a resident was experiencing distress. A Nurse Practitioner (NP) assessed the resident and instructed a registered staff member to use a medical device on the resident.

During an interview with the registered staff they stated that they were not familiar with how to use the device as it was different than devices they had used in the past.

Record review of the user's manual for the device was available with instructions for use.

Sources: Progress note in Point Click Care, staff interview with the registered staff, and the user's manual for the suction machine.
[739]