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

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Original Public Report

Report Issue Date: October 28, 2024
Inspection Number: 2024-1084-0004
Inspection Type: Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Berkshire Care Centre, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9 - 11, 2024

The following intake(s) were inspected:

- Intake: #00123416 -Critical Incident (CI) #2541-000032-24 - Resident to resident responsive behaviours.
- Intake: #00126957 -CI #2541-000039-24 - Resident to resident responsive behaviours.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a required assessment for a resident was completed as specified.

Rationale and Summary
A resident required an assessment be completed. On review of the assessment there were incomplete entries.

Review of the home's policy had set out clear direction on the completion of the specific assessment.

The Interim Director of Care (IDOC) had indicated they would have expected the staff to have assessed the resident.

Not ensuring the assessment was completed could have had a potential negative impact on the resident relating to early detection of a change in condition and a low risk for a potential delay in treatment if the overall reviewed assessment had indicated a change.

Sources: Resident's clinical records, the Home's Policy and staff interview.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that the Director was immediately notified of an incident of abuse of a resident.

Rationale and Summary
A resident was involved in an altercation with another resident. One of the residents was assessed to have had a physical injury.
A Critical Incident (CI) report was not submitted to the Ministry of Long-Term Care (MLTC) until two days later.

During an interview with the IDOC they had indicated incident of abuse should have been reported to the Director immediately and was not.

Not reporting incident of abuse to the Director immediately posed no risk to the resident.

Sources: CI, resident clinical records and staff interview.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

Introduction
The licensee failed to ensure that a resident had a specific strategy wholly implemented.

Rational and Summary
A section of the care plan for a resident had indicated a specific intervention. During the inspection the inspector observed the intervention not in place.

During an interview with the IDOC they indicated that the home's expectation would have been that the intervention would have been in place.

By not ensuring the intervention was in place the licensee did not fully implement the developed strategies for intervention of the resident's care.

Sources: Review of care plan, observations, and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

Introduction
The licensee failed to ensure that the the IPAC lead conducted required auditing of infection prevention and control practices in the home.

Specifically, in accordance with the IPAC Standard for Long-Term Care Homes, issued by the Director April 2022, revised September 2023, section 2.1 states the licensee shall ensure that the IPAC Lead conducts at a minimum, quarterly audits of specific activities performed by staff in the home, including the selection and donning and doffing of PPE.

Rational and Summary
During an onsite inspection the inspector had requested the home's quarterly audits for the selection and donning and doffing of PPE. The home was unable to provide audits specific to the selection and donning and doffing of PPE. IDOC, confirmed they did not have PPE audits completed in the last quarter to provide to the inspector.

By not completing the required auditing of the selection and donning and doffing of PPE the licensee cannot confirm its staff understand their IPAC roles and

responsibilities.

Sources: Review of available audits and staff interviews.