Ontario

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 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
Aug 1, 2019	2019_803748_0003	002794-19, 003114-19	Follow up

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

Wellington Park Care Centre
802 Hager Avenue BURLINGTON ON L7S 1X2

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

EMMY HARTMANN (748)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 27 and 28, July 2, 3, 4, 2019

The following intake was completed in this inspection: Log #003114-19 related to a follow up to compliance order #001 from inspection #2018_543561_0019 / 003554-17, 004647-18, 013926-18, 028391-18 regarding s. 19. (1), with a compliance due date of April 30, 2019; and log #002794-19 related to a follow up to compliance order #001 from inspection #2018_543561_0020 / 029425-17, 012406-18, 018450-18 regarding r. 50. (2), with a compliance due date of May 30, 2019.

This inspection was completed concurrently with Critical Incident Inspection (CIS) #2019_543561_0017, for which, Inspector #561 was present. Ontario Regulation 79/10 s. 30(2), example B was identified during the CIS inspection, and is issued in this report.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), the Documentation Nurse, the Clinical Practice Coordinator, the Nurse Program Manager for the Convalescent Care unit, the Director of Care, and the Executive Director.

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, audits, and policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_543561_0019	748
O.Reg 79/10 s. 50. (2)	CO #001	2018_543561_0020	748

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Clinical record review identified that resident #003 was admitted to the home on an identified date, after a medical procedure following an injury. The resident's altered skin integrity assessment completed on an identified date indicated that the resident had an altered skin integrity that required a specific treatment.

Progress notes documented on an identified date by RPN #105, suggested that the treatment was completed; however, upon review of the resident's records; there was no documentation of the treatment.

An interview with the Clinical Practice Coordinator #106, identified that they were responsible for all altered skin integrity in the building and that resident #003's altered skin integrity assessment was to be conducted once a week.

An interview with RPN #105, identified that they documented the resident's progress notes, after they were informed by the resident that their treatment was already done the day before. RPN #105 indicated that the altered skin integrity assessment would have also been completed when the treatment was completed. RPN #105 identified that the documentation for the altered skin integrity and treatment were not completed.

The policy titled "Skin and Wound Management Program", last revised March 2018, stated "Documentation of the progress of the wound and the effectiveness of the treatment is to be completed weekly in the electronic wound documentation system".

An interview with the Director of Care #101, indicated that it was an expectation that documentation for altered skin integrity and treatments were completed.

The home failed to ensure that any actions taken with respect to a resident under a program were documented.

B: A Critical Incident (CI) report number 1023-000002-19, log #001300-19, related to Improper/Incompetent treatment of a resident that results in harm or risk to a resident was reported to the Director on January 2019. The CI indicated that resident #002 sustained an injury; however, the cause was of an unknown origin.

Investigation notes were reviewed and identified that a PSW who provided direct care to the resident on an identified date, reported to RPN that resident had an injury. The investigation notes stated that RPN #112 failed to document their assessment of the resident's injury in the health record.

LTCH Inspector #561 interviewed PSW #108 who provided direct care to the resident on an identified date, and stated that they observed the resident to have the injury and reported it to the registered staff.

RPN #112 was interviewed by LTCH Inspector #561, and confirmed that the PSW reported the injury to them on an identified date; however, they did not document the assessment in the clinical record.

The DOC was interviewed and confirmed that the resident had the injury observed by PSW #108 on an identified date, and the RPN failed to document their assessment of the injury in resident #002's clinical record. (561)

The licensee failed to ensure that the assessment of resident #002's skin integrity was documented in their clinical record.

The home failed to ensure that any actions taken with respect to a resident under a program were documented. [s. 30. (2)]

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.