Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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 12, 2020	2020_555506_0008	013354-19, 020881-19, 024409-19	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

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

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

LESLEY EDWARDS (506)

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): February 28, March 4, 5 and 6, 2020.

Log #013354-19 - related to abuse and neglect
Log #020881-19 - related to abuse and neglect
Log #024409-19 - related to falls

During the course of the inspection, the inspector(s) spoke with Administrator, Regional Director of Operations, Director of Care (DOC), Resident Assessment Instrument Co-ordinator (RAI), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed clinical records, education records, policies and procedures, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the written plan of care for resident #002 identified that they were at risk for falls and had various interventions in place to prevent falls. On an identified date in February 2020, resident #002 was observed to not have the specified intervention in place. The Long Term Care Homes (LTCH) Inspector asked resident#002 if they could use the specified intervention and they confirmed that they could not. Interview with PSW #102 confirmed that the specified intervention was not available to the resident. Interview with the DOC on an identified date in February 2020, confirmed that the specified intervention was to be available at all times as specified in the resident's written plan of care.
[s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CIS) was submitted to the Director on an identified date in July 2019.

A review of the home's amended CI and investigation notes confirmed that the PSW involved in the incident did not follow resident #001's written plan of care.
A review of CIS, progress notes and staff interviews confirmed that on an identified date in July 2019, resident #001 needed assistance and PSW #108 went with the resident to provide care to resident #001 by themselves. PSW #108 reported they discovered resident #001 to have an injury during this process, but could not confirm when or how this had happened. Interview with RN #104 on an identified date in February 2020, confirmed that they were called to assess the resident and respond to the incident that took place. The RN confirmed that PSW #108 did not follow the resident's written plan of care. An interview with the Administrator on an identified date in February 2020, confirmed that they could not verify how the resident sustained the injury but could confirm that the written plan of care was not followed by PSW #108 for resident #001.
[s. 6. (7)]

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 the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003 was protected from abuse by resident #002.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in October 2019, under the category of resident-to-resident abuse.

A review of the CIS report, progress notes and staff interviews confirmed that on an identified date in October 2019, resident #003 sustained injuries from an altercation with resident #002. An interview with RN #104 on an identified date in March 2020, who had responded to the incident confirmed that resident #003 sustained several superficial injuries. The RN confirmed that resident #002 and #003 were immediately separated, assessed for injuries and an intervention was immediately initiated for resident #002. RN #104 confirmed on an identified date in March 2020, that this incident met the definition of abuse.
A review of resident #002's clinical record confirmed that the resident had a history of responsive behaviours towards staff and co-residents and there were previous documented incidents of altercations with resident #003 and resident #002.
Interview with the Administrator on an identified date in March 2020, confirmed that the incident met the definition of abuse.
The licensee failed to ensure that resident #003 was protected from abuse.
[s. 19. (1)]

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 resident #003 was protected from abuse by resident #002, to be implemented voluntarily.

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Issued on this 12th day of March, 2020

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

Original report signed by the inspector.