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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jul 21, 2021	2021_555506_0019	014894-20, 016593-20, 017122-20, 018122-20	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), DARIA TRZOS (561)

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): July 12, 13, 14, 15, 19, 20 and 21, 2021.

This inspection was completed related to the following intakes:

Log #018122-20- for Critical Incident System (CIS) 1023-000027-20 personal support services;
Log #017122-20- for CIS 1023-000026-20 for abuse and neglect;
Log #016593-20- for CIS 1023-000025-20 for abuse and neglect;
and
Log #014894-20- for CIS 1023-000022-20 for abuse and neglect.

This inspection was conducted concurrently with complaint inspection #2021_555506_0018.

Please note: Findings of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (7) related to plan of care were identified
in this inspection and have been issued in complaint Inspection Report 2021_555506_0018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Manager (ESM), housekeeping staff and residents.

During the course of the inspection, the inspectors completed an Infection Prevention and Control (IPAC) checklist, cooling requirements, observed resident care, meal and snack service, medication pass, reviewed resident health records, conducted interviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 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. 19. Duty to protect

Findings/Faits saillants :

The licensee has failed to ensure that resident #005 and resident #006 were protected from physical abuse by resident #004.

Ontario Regulation 79/10, section 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident System (CIS) report was submitted to the Director for an incident of physical abuse towards resident #006 from resident #004.

A review of clinical records confirmed that resident #004 used physical force towards resident #006 causing an injury.

A CIS report was submitted to the Director for an incident of physical abuse towards resident #005 from resident #004.

A review of clinical records confirmed that resident #004 was observed using physical force towards resident #005 and resident #005 sustained an injury.

Interviews with RN #112 and RPN #113 indicated that resident #004 used physical force towards resident #006 and resident #005 and caused injuries.

The ED confirmed that resident #004 did use physical force towards resident #006 and resident #005 causing injuries.

Sources: CIS reports, resident #004's, #005's and #006's progress notes; risk management reports; interviews with RPN #113, RN #112, and ED. [s. 19.]

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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that safe transferring and positioning techniques were used when assisting resident #003.

On an identified date in September 2020, PSW #111 was assisting resident #003 and the PSW turned away and heard a scream. When they turned back, the resident had slipped. The PSW assisted the resident back to the correct position.

Interview with PSW #111 and ED confirmed that unsafe positioning was used for resident #003.

Sources: CIS, resident #003's progress notes, risk management report, investigation notes, manufacturing instructions for the EZee Life shower chair; interview with PSW #111, RPN #113, and ED. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program in relation to resident hand hygiene before meals and at snack times.

The home's policy, "Hand Hygiene and Glove Use", stated "resident hand hygiene will be performed before and after eating and/ or drinking.

i. On an identified date in July 2021, on the specified home area, residents' hands were not cleaned upon entering the dining room for their meal, nor were residents offered encouragement or assistance with cleaning their hands. RPN #106 acknowledged and confirmed it was not done.
ii.On an identified date in July 2021, an observation of a snack pass in the identified home area was observed and several residents were not offered hand hygiene prior to receiving their snack, which was confirmed by PSW #109 and #110.

The DOC confirmed it was an expectation of staff to offer residents hand hygiene before and after eating as per the policy.

Not offering hand hygiene when indicated increased risk to residents as it served as a mechanism to prevent the transmission of infection.

Sources: the home's policy, "Hand Hygiene and Glove Use - Policy No:IFC H-15", revised date April 2021, a meal and snack observation and interviews with staff. [s. 229. (4)]

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 all staff participated in the implementation of the infection prevention and control program in relation to resident hand hygiene before meals and at snack times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the temperatures required to be measured, including in two resident bedrooms in different parts of the home and in one resident common area on each of the floors of the home were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

It was confirmed that staff were to be checking and recording the temperatures of two resident rooms, two common areas and the hallways on four home area's three times a day.

An interview with the ESM confirmed that they have eight cooling areas which were also common areas in the home and at this time temperatures were required to be taken in five identified areas in all four units of the home three times a day including the hallways.

A review of the Daily Air Temperature Recording Form dated for a specified time period in June 2021, until July 2021, identified that temperatures were not taken and recorded three times a day on all required cooling areas as per the legislative requirements.

The temperatures were not measured and documented as required.

Sources: review of the Daily Air temperature Recording Form and interviews with the ESM. [s. 21. (3)]

Issued on this 22nd day of July, 2021

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

Original report signed by the inspector.