



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 sous la
Loi de 2007 sur les foyers de
soins de longue durée

Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 9, 2013	2013_214146_0036	H-000327- 13	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

BARBARA NAYKALYK-HUNT (146)

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 2, 3, 4, 2013

This inspection was conducted concurrently with complaint inspections H-000008-13, H-002265-12 and H-002100-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW'S) and a resident.

During the course of the inspection, the inspector(s) reviewed policy and procedures related to abuse, the home's internal investigation notes and the resident's health record.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>
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WN #1: 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. In June 2013, resident #004 rang the call bell for assistance. A staff person answered the call bell, was verbally abusive and then moved the call bell out of reach of the resident. In an interview with the inspector in July 2013, the resident reported being very frightened by the anger and violence of the staff person. The resident reported being fearful more incidents would occur after reporting the original incident. [s. 19. (1)]
2. The home learned of the alleged abuse at 1000 am on a date in June. The alleged abuser was allowed to work a shift later that day. This information was confirmed by the DOC and the Administrator. The licensee did not protect the resident from abuse or possible further 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 the licensee of a long term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the staff or licensee, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**
- s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

Findings/Faits saillants :



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1. The home was notified of the alleged abuse at approximately 10 am on a date in June 2013 when the resident reported the incident to staff. The investigation was not initiated until the following day. This information was confirmed by the administrator and DOC. [s. 23. (1) (a)]

2. The home's abuse investigation was initiated on a date in June 2013. The results of the completed investigation have not been sent to the Director as of July 3, 2013. This information was confirmed by the administrator and the DOC. [s. 23. (2)]

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

(1)(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(2) the licensee shall report to the Director the results of every investigation undertaken under clause (1)(a) and every action taken under clause (1)(b), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
- 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. 2007, c. 8, ss. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The resident who had been allegedly abused on a date in June 2013 reported it to the home at approximately 10 am on the next day. The Critical Incident (CI) report was not sent in until the day following the report. No call was made to the after-hours pager. The Director was not immediately notified. This information was confirmed by the administrator and the DOC. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The home was notified by the resident on a date in June 2013 of the alleged abuse. The police were not called until 4 days later. The police were not immediately notified of the alleged abuse once the home was aware of the incident. This information was confirmed by the administrator and the health record. [s. 98.]



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Issued on this 9th day of July, 2013

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

B. NAYKALYK-MUNT