Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
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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 6, 2013	2013_214146_0039	H-000008-13	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 2,3,4, 2013

This inspection was conducted concurrently with Complaint inspection H-002265-12, H-002265-12 and CI inspection H-000327-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW's), admissions coordinator, residents and family members.

During the course of the inspection, the inspector(s) reviewed residents health records, medical service agreement, policy and procedures related to end of life care, medication administration and infection control; observed medication administration and dining room service.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. In December 2012, resident #003's roommate, resident #013 passed away. The deceased resident was not removed from the room until several hours later. Resident #003 was moved into the hallway and then to the lounge area. When resident #003 was in the room and/or in the bed, a curtain was pulled between resident #003 and resident #013.
When interviewed in July 2013, resident #003 verbalized remembering the day resident #013 passed away. Resident #003 could not recall the date but recalled being upset. No notations were in the progress notes for that date. The family was upset that resident #003 had to be in a room with a deceased resident for several hours. Resident #003 and family were not offered an alternate place to rest and visit on that day even though there was a vacant bed on the unit, as confirmed by the admissions coordinator.
The licensee did not fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.
This information was confirmed by the administrator, DOC, health record of resident #013, SDM of resident #003 and the admissions coordinator. [s. 3. (1) 1.]

Issued on this 9th day of July, 2013

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

BARBARA NAYKALYK-HUNT.