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 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
Jul 25, 2019	2019_543561_0017	032335-18, 001300-19	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

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): June 27, 28, 2019, July 2, 3, 4, 2019.

The following Critical Incident System (CIS) inspections were completed:
log #001300-19 - related to injury of unknown cause,
log #032335-18 - related to injury of unknown cause,

PLEASE NOTE: O. Reg 79/10 s. 30(2) was identified during this inspection and was issued under the Follow Up (FU) inspection report number 2019_803748_0003.

The following Follow Up (FU) inspections were completed concurrently with this inspection:
log #003114-19 - related to LTCHA, 2007 s. 19(1),
log #002794-19 - related to LTCHA, 2007 s. 50(2).

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Clinical Director of Care (CDOC), Clinical Practice Coordinator, Documentation Nurse, Physiotherapist, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector(s): observed the provision of care, reviewed clinical records, reviewed investigation notes, training records, annual evaluations of programs, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) Review of resident #010's written plan of care, identified that the resident required an identified level of assistance for activity of daily living (ADLs). It did not clearly identify the details of the level of transfer and if any devices required to be used.

Interview with PSW #119 who provided direct care to resident #010, stated that the resident was being transferred with a device. When asked how they knew that resident required the device, they stated that it was supposed to be documented in the care plan and Kardex.

Resident was observed during transfer by LTCH Inspector #561 and was transferred using a device.

B) Review of resident #012's written plan of care identified that the resident required an identified level of assistance for an identified ADLs using a device. Furthermore, the written plan of care stated that the resident required a different level of assistance for another ADL.

Resident #012 was interviewed and stated that the staff used a device for transferring; however, a different device for another ADL. The written plan of care and Kardex did not specify that this particular device was being used.

Interviewed PSW #117, who provided direct care to the resident and they confirmed that they used the devices identified by the resident. The PSW also stated that the identified level of assistance specified in the care plan meant that the specific device needed to be

used. Interviewed two more PSWs (PSW #109 and #118) and they both confirmed this statement.

The resident was assessed on an identified date in 2018, and was safe on both devices.

The DOC was interviewed and stated that the written plan of care should have clearly identified what type of devices were to be used. The identified level of assistance used for resident #012 did not mean that that specific device was required. The DOC confirmed that resident #010's and #012's written plans of care did not provide clear directions to staff related to the level of assistance for ADLs.

The licensee failed to ensure that there was a written plan of care for resident #010 and #012, that set out clear directions to staff and others who provided direct care to the residents. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, 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 failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report, related to Improper/Incompetent treatment of a resident that results in harm or risk to a resident was submitted to the Director. The CI indicated that resident #002 sustained an injury.

Three PSWs (PSW #108, #109, and #110) were interviewed and stated that resident was being transferred with an identified level of assistance.

The plan of care in effect at the time of the incident, indicated that resident required an identified level of assistance that was not consistent with the level of assistance provided to resident by PSWs #108, #109 and #110.
The quarterly assessment completed by the Physiotherapist on an identified date in 2018, stated that resident required a device for transfers. Clinical record review indicated that there were no changes to the transfer status between 2018 and an identified date in 2019.

Physiotherapist was interviewed and stated that resident #002 was to be transferred via an identified device. The resident was not safe using the transfer provided by the identified PSWs due to their health condition.

In an interview with the DOC they stated that resident #002 was to be transferred as assessed by the Physiotherapist and as indicated in the plan of care.

The licensee failed to ensure that staff used safe transferring devices or techniques when assisting resident #002 to be transferred. [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 the 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any program, the program was complied with.

In accordance with O. Reg 79/10 s. 48(1) and in reference to O. Reg 79/10 s. 49(2), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury and to ensure that when a resident had fallen, the resident was reassessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Specifically, the licensee did not comply with their Falls Prevention Program, revised June 2018.

The home's Falls Prevention Program, revised June 2018, stated that the post fall assessment was to be done at a minimum every shift for the following twenty-four (24) hours for potential complications from the fall. This assessment was to be documented in the electronic interdisciplinary notes.

The Falls Prevention Program had a policy titled "Head Injury Routine", index I.D RCS E-35, review date July 2018, and indicated that the Head Injury Routine (HIR) was to be initiated for any falls resulting in a head injury or suspected head injury from unwitnessed fall.

Resident #002's clinical record review identified that the resident had an unwitnessed fall on an identified date in 2019 and was found by PSW #120. Progress notes identified that registered staff #115 completed an assessment; however, did not identify this incident as a fall. The clinical record review indicated that there was no documentation of the post fall assessment completed on every shift for 24 hours after the fall. Clinical records also identified that the head injury routine (HIR) was not initiated after the fall.

PSW #120 and registered staff #115 were interviewed and confirmed the resident had a fall on the identified date.

Interview with the Clinical Director of Care/ Falls Lead indicated that the homes Falls Prevention Program included a definition of a fall and the post fall protocol should have been implemented for this resident.

The licensee failed to ensure that the Falls Prevention Program was complied with in relation to post fall assessments. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 7th day of August, 2019

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

Original report signed by the inspector.