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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date September 16, 2022
Inspection Number 2022_1023_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Wellington Park Care Centre, Burlington

Lead Inspector
Lisa Bos (683)

Additional Inspector(s)
Paola Carla Meyer (740860), Stephanie Smith (740738)

Inspector Digital Signature
Lisa Bos
Digitally signed by Lisa Bos
Date: 2022.10.04 11:50:48 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1-2 and 6-9, 2022

The following intake(s) were inspected:

- Log #011834-21 (CIS #1023-000008-21) related to the prevention of abuse and neglect;
- Log #016002-21 (CIS #1023-000010-21) related to falls prevention and management; and
- Log #015229-22 (Complaint) related to nutrition and hydration, resident care and support services and medication management.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

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During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 268 (4) 3

The licensee has failed to ensure that hand hygiene products provided in the home were not expired.

Observations in the home revealed that alcohol-based hand rub (ABHR) outside a meeting room, was expired. An interview with the Infection Prevention and Control (IPAC) Lead verified that the ABHR was expired. The home remedied the non-compliance the same day, by replacing the expired ABHR.

Sources: Observations; interview with the IPAC Lead.

Date Remedy Implemented: September 7, 2022 [740738]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (7)

The licensee has failed to ensure that a resident's plan of care related to fall prevention strategies was followed.

Rationale and Summary

A resident sustained a fall which resulted in an injury. Their plan of care included a falls prevention strategy to reduce their risk of falls.

A Personal Support Worker (PSW) confirmed the location where the resident was left, prior to leaving for their break. A Registered Practical Nurse (RPN) indicated the PSW left the resident in the location, without informing them. They confirmed the resident was not to be left in the location without supervision.

Both the RPN and the Executive Director (ED) confirmed that the PSW did not follow the resident's plan of care related to their fall prevention strategies.

By not following the resident's plan of care, the resident's risk of falling was increased.

Sources: Critical Incident (CI) report; a resident's records; home's investigative notes and interviews with the ED, an RN, RPN and PSW.

[740860]

WRITTEN NOTIFICATION: PERSONAL ITEMS AND PERSONAL AIDS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 41 (1) (a)

The licensee has failed to ensure that two resident's denture cases were labelled.

Rationale and Summary
i) A resident's denture case was observed without a label. A PSW reported that a label was not required as they were the only resident in the shared room that wore dentures.

ii) Another resident's denture case was observed without a label in their shared room. A Registered Nurse (RN) acknowledged that it was not labelled and stated that all resident denture cases were required to be labelled.

There was risk that residents may not receive the correct dentures when the denture cases were not labelled, which could result in the transmission of infection and may affect oral health/ intake.

Sources: Resident clinical records; observations in the home; interview with a PSW, RN and other staff.

[683]

WRITTEN NOTIFICATION: LAUNDRY SERVICE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 95 (1) (a) (ii)

The licensee has failed to ensure that procedures were developed to ensure that residents' dentures were labelled.

Rationale and Summary
A complaint was submitted to the Director regarding a resident wearing dentures that did not belong to them.

A PSW reported that denture cases were labelled, but not the dentures. They stated that if dentures were ever lost or misplaced, they asked other staff if they remembered who the dentures belonged to and sanitized them prior to giving them back to a resident.

The Interim DOC and an RN acknowledged that the home labelled denture cases, but did not have a process in place, or the appropriate materials available, to label resident dentures.

There was risk that resident dentures could be mixed up, which may affect oral health and food intake, when there was not a process in place for labelling them.

Sources: Resident clinical records; complaint intake; interview with the Interim DOC, an RN and other staff.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, stated under section 9.1, that Additional Precautions shall include (d) evidence-based practices for combined precautions and (f) additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal.

During observations in the home, Droplet/Contact Precautions signage was posted on the door to a resident's room. A PSW was observed inside the room providing care, wearing a gown, gloves, and medical mask, however, was not wearing a face shield or goggles for eye protection.

A PSW and the IPAC Lead verified that when rooms had Droplet/Contact Precautions signage posted, the PPE required included gown, gloves, face mask and eye protection with a face shield or goggles. The IPAC Lead acknowledged that staff should have been wearing eye protection in the resident's room.

Failure of the home to ensure utilization of required PPE for Droplet/Contact Precautions, could lead to increased risk for spread of infection for the resident and others.

Sources: Observations; interviews with a PSW and the IPAC Lead.

[740738]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 123 (2)

The licensee has failed to comply with the written policies and protocols that were developed for the medication management system to ensure the accurate administration of all drugs used by a resident.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that policies and protocols were developed for the medication management system to ensure the accurate administration of all drugs used in the home, and that the policy was complied with.

Specifically, staff did not comply with their policy and procedure regarding medication reconciliation which stated that on admission, the nurse was required to obtain an accurate and complete medication history by checking at minimum two sources of information, which were to be documented on the "New Admission Order Form."

A new resident was admitted to the home and their medication record from their community pharmacy indicated that the resident had orders for two medications, which were discontinued prior to their admission.

The resident's "New Admission Order Form" listed the discontinued medications, and the source of medication information was identified as the community pharmacy list. There was no second source of medication information documented, as per the home's medication reconciliation policy. The orders were signed by the resident's physician and the resident received the medications for several days, until concerns were raised about their medications, the error was confirmed, and the orders were discontinued.

The Interim DOC acknowledged that there was only one source of medication information selected on the "New Admission Order Form," and that staff did not follow the home's medication reconciliation policy.

Failure to check a minimum of two sources of information when completing medication reconciliation as per the home's policy put residents at risk of adverse effects.

Sources: A resident's clinical record; Policies and Procedures: Manual for Medisystem Serviced Homes, Section C: Patient Care; interview with the Interim DOC and other staff.

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WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 147 (2) (a)

The licensee has failed to ensure that every medication incident involving a resident was reviewed and analyzed.

Rationale and Summary

A resident was admitted to the home and their admission orders included two medications, which were previously discontinued and no longer indicated. The resident received the medications for several days, until concerns were raised about their medications, and the orders were discontinued.

The Interim DOC acknowledged that a medication incident report was not completed, and as a result, it was not reviewed and analyzed, and it should have been.

Failure to review and analyze the medication incident had the potential for errors of a similar nature impacting this resident or others.

Sources: A resident's clinical record; interview with the Interim DOC and other staff.

[683]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 147 (3) (a)

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home to reduce and prevent medication incidents.

Rationale and Summary

A request was made for the quarterly review of medication incidents. The Interim DOC identified that a quarterly review was completed in March 2022 and was not completed since. They stated that the next one was scheduled for June 2022 and acknowledged that they missed a quarter. There was no documentation to be provided or reviewed.

There was a risk that necessary changes and improvements to prevent medication incidents would not be implemented, as a review of the medication incidents in the home was not being conducted quarterly.

Sources: The home's Medication Incident Reports for 2022; interview with the Interim DOC.

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