Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 16, 2024

Inspection Number: 2024-1023-0002

Inspection Type:
Critical Incident

Licensee: Rykka Care Centres LP

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

Lead Inspector	**Inspector Digital Signature**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2024.08.21 11:53:29 -04'00'

Additional Inspector(s)
Harshita Kaur (000846)
Alison Brown (000841)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 19, 22-26, 2024

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00109055/CI #1023-000004-24 was related to infection prevention and control.
- Intake #00109970/CI #1023-000005-24 was related to falls prevention and management.
- Intake #00111463/CI #1023-000006-24 was related to resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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.

A physiotherapist made recommendations related to a resident's care needs.

The care plan was not updated to reflect the recommendations.

Staff confirmed the recommendations were not included in the revisions to the resident's care plan.

Direct care staff confirmed that the recommended interventions were in place.

Failure to ensure the resident's care plan was updated accordingly could negatively impact the continuity of care and the resident's safety.

Sources: Review of resident's clinical files, interviews with staff, observations of resident's room.

Date Remedy Implemented: July 25, 2024

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management policy to identify pain for a resident was complied with.

In accordance with O. Reg. 246/22, s. 11 (b), the licensee is required to ensure that

the Pain Management policy of the long-term care home is to be complied with.

Specifically, the staff did not comply with the Pain Management Policy of the LTCH on ensuring that a pain assessment was completed with the onset of new pain for a resident.

Rationale and summary
A resident voiced new pain on a specific date.

The resident's clinical records indicated they complained of new pain.

The long-term care home's pain management policy indicated that a pain assessment was to be completed at the onset of new pain.

Two staff acknowledged that a pain assessment was not completed when a resident complained of a new onset of pain.

Failure to comply with the licensee's written policy on pain management on ensuring that a clinically appropriate pain assessment instrument was completed with the new onset of pain, resulted in failure to assess and identify the presence of pain.

Sources: Pain Management Policy' (Index I.D: RCS G-60, Revised Date: April 15, 2024), Critical Incident System (CIS) report number 1023-000006-24, resident progress notes, interview with staff.

B) The licensee has failed to ensure that the pain management policy to identify pain for a resident on specific date was complied with.

In accordance with O. Reg. 246/22, s. 11 (b), the licensee is required to ensure that the pain management policy of the long-term care home is to be complied with.

Specifically, staff did not comply with the home pain management policy ensuring that a pain assessment was completed with the onset of new pain for a resident.

Rationale and summary
A resident's clinical records indicated that they had identified pain following an incident.

The long-term care home's pain management policy indicated that a pain assessment was to be completed at the onset of new pain.

A staff member confirmed it was the home's policy to conduct a pain assessment, specifically at the onset of new pain.

Failure to comply with the licensee's written policy on pain management, specifically at the onset of new pain could have led to a lack of treatment and care related to the resident's pain needs, further placing the resident at risk of ongoing pain and discomfort.

Sources: Pain Management Policy' (Index I.D: RCS G-60, Revised Dat: April 15, 2024), progress notes, post fall assessment, interview with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that staff followed IPAC measures related to contact and droplet precautions as part of the recommendations issued by the Chief Medical Officer of Health (CMOH).

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024) indicates to 'provide appropriate waste receptacles with lids in clients/patients/residents' rooms for PPE disposal'.

Rationale and summary
A staff member was observed exiting a resident room who was required to be on contact/droplet precautions. The staff member doffed their gloves and disposed of them in the resident's open garbage can in their washroom. The staff then removed their gown and walked down to the end of the hallway to the home area Spa Room and disposed of their gown within the room.

Later that same day inspector observed another staff member providing care to a resident who required droplet precautions. After providing care the staff member doffed their gown and gloves into the small open receptacle in the resident's bathroom.

Failing to provide staff with appropriate waste receptacles with lids in resident

rooms may increase the transmission of infection as staff must walk through the hallway with contaminated PPE or dispose of them in open receptacles in resident rooms.

Sources: observations, interview with staff, document: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024).

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

- Provide education to all direct care staff and any staff who assist with feeding on four moments of hand hygiene, specifically as it relates to staff hand hygiene at meals.
- Provide education to all direct care staff on resident hand hygiene at snack time.

- Conduct and retain weekly audits of hand hygiene (specifically meal and snack activities) including the date, staff member completing the audits, any non-compliance found and any corrective action taken.
- Provide education to all direct care staff on PPE requirements including appropriate selection application, removal and disposal as per the home's Additional Precautions policy and PIDAC guidelines.
- Conduct and retain weekly audits of donning and doffing including the date, staff member completing the audits, any non-compliance found and any corrective action taken.
- Document and retain record of the above education provided including the date, staff members who attended and the staff member who provided the education.

The above records must be readily available for Inspector review.

Grounds

The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control.

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 9.1, indicates that the licensee shall ensure that Additional Precautions are followed in the IPAC program, including appropriate selection application, removal, and disposal of personal protective equipment (PPE).

Rationale and summary

An area of the home was in outbreak during this inspection. The inspector observed the following in the home area:

i) A staff member was observed not wearing the correct PPE when providing care for a resident who required contact/droplet precautions.

ii) A staff member was observed not wearing the correct PPE when providing care for a resident who required droplet precautions. When the staff member completed care in the room, they doffed the gown and gloves in the resident's bathroom garbage can and continued wearing the same mask.

iii) A staff member was observed not wearing the correct PPE when providing care for a resident who required contact/droplet precautions. After completing care for the identified resident, the staff member then assisted the other resident in the room, without doffing PPE. The staff member then exited the room. Doffed gown and gloves; continued wearing the same mask.

iv) A staff member was observed not wearing the correct PPE when providing care for a resident who required contact/droplet precautions.

v) A staff member was observed exiting a resident's room. Signage was on the door indicated contact/droplet precautions. The staff member was wearing the required PPE. Upon exiting the resident's room the staff member doffed their gown and gloves, performed hand hygiene, then continued down the hallway wearing their face shield and mask.

vi) A staff member exited a resident's room that had signage indicating contact/droplet precautions. The staff member doffed their gown and gloves, performed hand hygiene and continued down the hallway still wearing their face shield and mask.

vii) Two staff members were observed exiting rooms after assisting residents that required contact/droplet precautions. Both staff members did not doff their masks

after exiting rooms. Both staff were not wearing eye protection or face shield.

The home's policy 'Additional Precautions (IFC F-05) Revised July 31, 2023, references Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, Provincial Infectious Diseases Advisory Committee (PIDAC), Third Revision: November 2012, which indicated to wear a mask and eye protection when within two metres of the client/patient/resident on Droplet Precautions. In addition, it states that if the health care provider needs to leave the room, the PPE must be removed and discarded. Fresh PPE must be worn if the health care provider re-enters the room.

The IPAC Lead indicated that staff should be fully doffing their PPE when exiting a resident's room and should not continue to wear shield and mask to another resident's room. IPAC Lead also indicated that staff should be wearing the following PPE when a resident was on droplet or contact/droplet precautions: gown, gloves, mask/N95, face shield.

Failing to follow additional precautions IPAC practices may have increased risk of infectious disease transmission and exposure of COVID to other residents.

Sources: observations, interview with IPAC Lead and Infection Control Coordinator, home's policy 'Additional Precautions (IFC F-05) Revised July 31, 2023, Provincial Infectious Diseases Advisory Committee (PIDAC), Third Revision: November 2012.

B) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 9.1 (b), indicates that the licensee shall ensure that Routine Practices are followed in the IPAC program, including the four moments of hand hygiene (before initial resident/resident environment contact; before any

aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and summary
Lunch service was observed in a home area. Staff were observed providing residents with hand wipes to perform hand hygiene (HH) prior to meal service. Staff were observed to remove a wipe from the wipe container and pass it to a resident. Between providing clean wipes to residents, staff were also observed collecting soiled wipes from residents who had completed their hand hygiene. Staff did not perform HH between taking a soiled wipe from a resident and providing a new wipe to another resident.

IPAC Lead indicated that staff should perform HH before handing out wipes, provide fresh wipes to all residents before collecting soiled wipes from residents, and that hand hygiene must be performed if they touch a soiled wipe.

Failing to perform hand hygiene before and after resident/resident environment contact may increase the transmission of microorganisms.

Sources: observations, interview with IPAC Lead, home's policy 'Hand Hygiene and Glove Use' IFC H-15 (revised Nov 10, 2023).

C) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 10.2 (c), indicated the hand hygiene program for residents shall include: c) Assistance to residents to perform hand hygiene before meals and snacks;

Rationale and summary

The inspector made the following observations on a home area: morning snack service was observed on a specific date, and afternoon snack service was observed on another date.

The staff member serving snacks on a specific date did not offer or assist with hand hygiene for residents when serving snack that day.

A staff member was serving snacks on another date and did not offer or assist with hand hygiene for residents when serving snack. The staff member indicated to the inspector that they did not perform HH for residents at snack time.

The IPAC Lead indicated that staff should be performing HH for residents before serving food and drinks, at all meals and snacks.

Failing to perform resident hand hygiene before serving food and drinks may increase the risk of transmission of microorganisms.

Sources: interview with staff and IPAC Lead, observations, 'Hand Hygiene and Glove Use' IFC H-15 (revised Nov 10, 2023).

This order must be complied with by
November 6, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.