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
Nov 6, 2013	2013_105130_0035	H-001459-12,H-000469-13	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

GILLIAN TRACEY (130)

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): October 16 and 17, 2013

This inspection was conducted in part by Inspectors: Cathy Fediash and Cynthia DiTomassio.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Staff, personal support workers and residents related to H-001459-12 and H-000469-13.

During the course of the inspection, the inspector(s) Interviewed staff and residents, reviewed clinical records, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Personal Support Services

Responsive Behaviours

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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse.

a) On a specific date in 2013, resident #003, with known responsive behaviours, struck resident #002 , which resulted in pain and a minor injury. [s. 3. (1) 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 all residents are protected from abuse, to be implemented voluntarily.

WN #2: 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

a) Resident #001 did not have a plan in place to direct staff on the level of assistance and frequency of foot care to be provided. Progress notes and assessments reviewed indicated the resident was at moderate risk to injure self, at times exhibited responsive behaviours, however these problems were not identified in the plan with goals and interventions to manage these behaviours. [s. 6. (1) (a)]

2. The licensee did not ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

a) On a specified date in 2012, the plan of care developed by nursing staff for resident #001 identified, specific safety devices in place, however during the same time frame in 2012, the plan also indicated other safety devices, which were conflicting. On a specific date in 2012, physiotherapy staff revised the plan, indicating one staff assistance with side by side transfers and bed mobility, however, the plan developed by nursing still indicated two staff assistance with side by side transfers and extensive assistance with bed mobility. The plan was not clear regarding safety device use or number of staff required to assist with transfers and bed mobility. [s. 6. (1) (c)]

3. The licensee did not ensure that all staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

a) The clinical record of resident #001 had conflicting statements regarding the post operative surgical site. The nursing notes upon return from hospital on a specified date in 2012, indicated the resident had a surgical site to an identified area, however, the physician's note identified the surgical site was to a different area. The readmission note completed upon return to the home described the affective area to include sutures, however a progress note completed around the same time frame, described the affected area to include staples. On another date in 2012, nursing staff documented a treatment to the affected area but described the incorrect location.

b) Resident #002 was admitted to the home in 2013. The resident sustained falls on three identified dates in 2013, however, the Quarterly Minimum Data Set (MDS)

assessment completed after the falls, stated the resident had "no falls this quarter". [s. 6. (4) (a)]

4. The licensee did not ensure that care set out in the plan was provided to the resident as specified in the plan.

a) According to the plan of care, resident #002 was at risk for falls and required a safety device in place. On an identified date in 2013, the resident sustained a fall from bed. Documentation and staff confirmed the safety device was not in place at the the time of the incident. [s. 6. (7)]

5. The licensee did not ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

a) Resident #001 sustained an injury as a result of a fall on in 2012 and a second injury later in 2012. The plan of care was not revised upon return from hospital on either occasion to reflect the post operative care, the need for pain management despite expressions of pain and need for analgesics. In 2012, the physician recorded a change to the resident's health status, however the plan of care was not revised to reflect this change.

b) According to a progress note dated in 2012, resident #001 was found sliding out of their wheelchair while a safety device was applied. The seatbelt was noted to be "around the resident's chest, closer to their neck". On another date in 2012, the resident slid from their wheelchair and was found sitting on the footrests, holding onto the seatbelt which, according to the record, was around their head. Staff removed the safety device and repositioned the resident back in the wheelchair. According to progress notes, and the plan of care, the resident continued to have a the safety device in use, despite these two incidents.

c) According to the plan of care, resident #002 had sustained at least two falls since admission. The resident sustained a third fall in 2013; the post fall assessment indicated "call bell in reach" and " safety device in use; however, neither intervention was identified on the plan of care. [s. 6. (10) (b)]

6. The licensee did not ensure that the resident was reassessed and the plan of care

reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

b) Resident #001 was identified to be at risk for falls and had sustained three recorded falls within the first three days of admission, all of which occurred as a result of self transfers from bed. On two identified dates in 2013, the resident sustained a forth and fifth fall from bed, which resulted in injury. The resident was assessed after each fall, however, according to the plan of care, the home did not consider alternative approaches until after the resident had sustained serious injury. [s. 6. (10) (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 that there is a written plan of care for each resident that sets out the planned care for the resident, that the plan of care sets out clear directions to staff and others who provide direct care to resident, that all staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, ensure that the care set out in the plan of care is provided to the resident as specified in the plan, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, when the resident's care needs change or when care set out in the plan has not been effective,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.
a) The medical directive indicated "on rectal exam prior to 3rd day, if no bowel movement, on day 3 give milk of magenesia (mom) x 1, on day 4 dulcolax suppository x 1, on day 5 give fleet enema x 1".

It was noted on two identified dates in 2012, staff gave a suppository to resident #001 without administering mom. On another date, a suppository was given at 1511 hours and recorded as being effective with no prior dose of mom. On the same date at 2206 hours, staff administered a fleet enema. There was no written evidence found to indicate that rectal exams had been done on any of the identified dates.

b) Resident #003 received suppositories on at least four occasions in 2013, with no prior dosage of mom or rectal exam.

c) Resident #004 received mom on a specific date 2013 and a suppository the day after; the drugs were found to be ineffective. On the fifth day, the resident was administered another suppository, but should have received a fleet enema. [s. 131. (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 drugs are administered to residents in accordance with the directions for use, specified by the prescriber, to be implemented voluntarily.

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Issued on this 14th day of November, 2013

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