Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 11, 12, 17, 18, 20, 23, 24, 26, May 14, Jun 26, 2012	2012_064167_0007	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and staff on the unit related to log # H-000451-12.

During the course of the inspection, the inspector(s) conducted a review of the nursing staffing patterns for the home, conducted a tour of dining rooms and lounges and reviewed the home's investigation notes, the home's policies and procedures related to medication administration and medication incident protocols.

PLEASE NOTE: A dietary inspection related to this complaint was conducted simultaneously with this inspection. Please refer to report for Inspection # 2012_122156_0010.

The following Inspection Protocols were used during this inspection:

Medication

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that is available in every area accessible to residents.

a) It was noted during a tour of the lounge areas in the home that the first, second and third floor resident lounge areas on the east wing were not equipped with a resident-staff communication and response system.
b) It was noted during a tour of the home that the dining room on second floor west does not have a call system that is accessible. The call bell is located in the bathroom that is adjacent to the dining room but this bathroom is kept locked and is only accessible to staff.
c) It was also noted that the dining room in the west wing on the lower level does not have a call system accessible. The only call bell is located in a resident bathroom that is across the hall from the dining room.

Discussions with the Administrator and the Director of Care confirmed that there is no other call system accessible to residents in these areas. [s. 17 (1)(e)]

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 subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee did not ensure that no drug was used or administered to a resident in the home unless the drug has been prescribed for the resident.

During the medication pass, an identified resident took medication that was crushed and placed in food belonging to a co -resident. This medication was not prescribed for the identified resident and had been prescribed for the co-resident. The registered staff member had placed the medication in the co-resident's food and had turned away and when they turned around again they observed that the identified resident had put the co-resident's medication in their mouth. The staff member immediately asked the identified resident to spit out the medication which they did. The registered staff member then notified the physician and the Power of Attorney for the identified resident related to the incident. No ill effects were suffered by either resident. [r. 131. (1)]