

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 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 Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office 119 King Street West, 11th Floor HAMILTON, ON, L8P-4Y7 Telephone: (905) 546-8294 Facsimile: (905) 546-8255

Bureau régional de services de Hamilton 119, rue King Ouest, 11iém étage HAMILTON, ON, L8P-4Y7 Téléphone: (905) 546-8294 Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 5, 7, 22, 2011	2011_060127_0052	Critical Incident
Licensee/Titulaire de permis		
RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORO Long-Term Care Home/Foyer de soir		-
COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSIS	SAUGA, ON, L5B-1B5	
Name of Inspector(s)/Nom de l'inspe	cteur ou des inspecteurs	
RICHARD HAYDEN (127)		
ln:	spection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the administrator and directors of care regarding H-002157-11, H-002165-11 and H-002257-11.

During the course of the inspection, the inspector(s) reviewed management's documentation of the investigations; reviewed policies and procedures; reviewed staff training modules offered by the home and staff attendance sheets for several training dates.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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 le Loi de 2007 les foyers de soins de longue

Legend	Legendé
VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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)	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 sult 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. 19. Duty to protect Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants:

On December 5, 2011, the inspector confirmed the following information:

- 1. An identified resident was physically abused by a personal support worker (PSW) in 2011. The PSW refused to provide care to the resident after several requests; grabbed, shook and struck him/her; and then placed the call bell cord out of reach. The resident was found in wet bedding at the beginning of the next shift by another PSW. A completed skin assessment indicated he/she had injuries.
- 2. An identified resident was physically abused by a PSW in 2011. The resident complained of severe pain and was assessed by the physician and in-home X-ray was ordered. X-ray results confirmed an injury. The resident was able to identify a PSW who had provided care in a rough manner that resulted in the injury.

Issued on this 18th day of January, 2012

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