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

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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
May 8, 2014	2014_201167_0013	H-000702-13,H-000817-13	Critical Incident System

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 2, 6, 7, 2014

This inspection was completed related to Critical Incident Logs: H-000702-13, H-000817-13 and H-000820-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, residents and nursing staff.

During the course of the inspection, the inspector(s) observed resident care and staff to resident interaction, conducted a review of the health files for the identified residents, reviewed investigation notes completed by the home and relevant policies and procedures.

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 19. Duty to protect

Specifically failed to comply with the following:

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 :

1. The licensee did not ensure that resident # 003 was protected from emotional and physical abuse by a staff member.

A) Resident # 003 reported to a family member that an identified Personal Support Worker (PSW #1)refused to provide for their care needs related to continence and left

them in a soiled brief for the next shift to clean up. The resident alleged that they had requested assistance from PSW #1 on on an identified date in related to having soiled their brief and that PSW #1 did not come back to their room until at least two hours later and told them that the evening staff could clean them up. Resident # 003 also indicated that PSW #1 was very rough with them when care was provided and that they were afraid of this staff member.
B) The alleged abuse was reported to the Director of Care who notified the Ministry of Health, the physician and the police related to the alleged incident.
C) PSW #1 had received training related to Elder Abuse, Residents' Rights, Abuse Prevention/ Neglect in 2013.
C) The home conducted an investigation and PSW #1 received disciplinary action. [s. 19. (1)]

2. The licensee did not ensure that resident # 004 was protected from emotional abuse by a staff member.

A) On an identified date in 2013, resident # 004 reported to their family member that an identified Personal Support Worker (PSW #3) refused to provide toileting as per their plan of care when the resident requested it.
B) When the resident again requested to be toileted, PSW #3 reportedly became very angry and threatening causing the resident to become afraid.
C) The home notified the Ministry of Health and initiated an investigation into the alleged incident.
D)PSW # 3 had received training related to Residents' Rights and Resident Abuse and Neglect in 2013
E) PSW #3 received disciplinary action as a result of the incident. [s. 19. (1)]

3. The licensee did not ensure that resident # 002 was protected from abuse by a staff member.

A) On an identified date in 2013, resident # 002 reported to a staff member that an identified Personal Support Worker (PSW #2) pushed resident #002 up against the wall hitting their head when PSW #2 was providing the resident's continence care.
B) Resident # 002 indicated that PSW #2 was always rough with them and had an attitude and was rude. The resident indicated that they were afraid of PSW #2.
C) Resident # 002 had recorded the incident and relayed the allegation of abuse to their family member.
D) The home notified the Ministry of Health and the police of the alleged incident and

submitted a critical incident report to the Ministry of Health.
E) It was noted that PWS #2 had received training related to Prevention of Abuse within the two months prior to the incident and had signed a form indicating their understanding of the policy.
F) The accused staff member received disciplinary action related to the incident. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 15th day of May, 2014

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

Marilyn Tone

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167)
Inspection No. / No de l'inspection :	2014_201167_0013
Log No. / Registre no:	H-000702-13,H-000817-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 8, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NICOLE FISHER

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_207147_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that residents at the home are protected from abuse by staff members.

Grounds / Motifs :

1. LTCHA c.8, s.19(1) was previously issued as a CO in January 2012 and again as a CO in October 2013.

The licensee did not ensure that resident # 003 was protected from emotional and physical abuse by a staff member.

A) Resident # 003 reported to a family member that an identified Personal Support Worker (PSW #1) refused to provide for their care needs related to continence and left them in a soiled brief for the next shift to clean up. The resident alleged that they had requested assistance from PSW #1 on an identified date in 2013 related to having soiled their brief and that PSW #1 did not come back to their room until at least two hours later and told them that the evening staff could clean them up. Resident # 003 also indicated that PSW #1 was very rough with them when care was provided and that they were afraid of this staff member.
B) The alleged abuse was reported to the Director of Care who notified the Ministry of Health, the physician and the police related to the alleged incident.
C) PSW #1 had received training related to Elder Abuse, Residents' Rights and Abuse Prevention/ Neglect in 2013.
C) The home conducted an investigation and the identified staff member received disciplinary action.

The licensee did not ensure that resident # 004 was protected from emotional abuse by a staff member.

A) On an identified date in 2013, resident # 004 reported to their family member that an identified Personal Support Worker (PSW #3) refused to provide toileting as per resident # 004's plan of care when the resident requested it.
B) When the resident again requested to be toileted, PSW #3 reportedly became very angry and threatening causing the resident to become afraid.
C) The home notified the Ministry of Health and initiated an investigation into the alleged incident.
D) PSW #3 had received training related to Residents' Rights and Resident Abuse and Neglect in 2013
E) PSW #3 received disciplinary action as a result of the incident.

The licensee did not ensure that resident # 002 was protected from abuse by a staff member.

A) On an identified date in 2013, resident # 002 reported to a staff member that an identified Personal Support Worker (PSW #2) pushed them up against the wall hitting resident # 002's head when PSW #2 was providing the resident's continence care.
B) Resident # 002 indicated that PSW #2 was always rough with them and had an attitude and was rude. The resident indicated that they were afraid of PSW #2.
C) Resident # 002 had recorded the incident and relayed the allegation of abuse to their family member.
D) The home notified the Ministry of Health, the physician and the police of the alleged incident and submitted a critical incident report to the Ministry of Health.
E) It was noted that PSW #2 had received training related to Prevention of Abuse within the two months prior to the incident and had signed a form indicating their understanding of the policy.
F) The accused staff member received disciplinary action related to the incident. (167)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 22, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARILYN TONE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office