



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée

Health System Accountability and
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Performance Improvement and
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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
Mar 20, 2014	2014_188168_0008	H-000534- 13/H-000536 -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

DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

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

LISA VINK (168), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): February 27, 2014.

This Inspection Report includes inspection findings for log numbers H-000534-13, H-000536-13 and H-000248-14.

Findings of non-compliance identified during this inspection related to LTCHA, 2007, section 6 are included in Complaint Inspection Report H-000193-14 H-000194-14, which was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager (FSM), registered nursing staff, personal support workers (PSW's) and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services and reviewed relevant documents including but not limited to: policies and procedures, investigative notes and clinical records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral. CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 :



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1. Not every resident was protected from abuse.

A. In 2013, resident #001 was verbally abused by a staff member, which was witnessed by the clinical DOC. The staff member was heard yelling at the resident in a loud tone. During the home's internal investigation the employee admitted that they yelled at the resident and was aware that their actions were not appropriate.

B. In 2013, resident #002 was verbally abused by a staff member which was witnessed by the FSM. The FSM observed the employee standing in front of the resident talking loudly and aggressively, in response to an action of the resident.

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 every resident is protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).

3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).

4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).

5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :



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1. A person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to a resident did not immediately report the suspicion and the information upon which it was based to the Director.

The Director was not immediately notified following an incident of suspected resident abuse. In February 2014, residents #003 and #004 were involved in an altercation, resulting in resident #004 being hit by the co-resident. The Director was not immediately notified of the incident. A Critical Incident was not submitted until two days later. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that results in harm or a risk of harm to a resident immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 20th day of March, 2014

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

LVINK