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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2014	2014_163109_0031	T-036-14	Resident Quality Inspection

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

SUSAN SQUIRES (109), JANICE PITTS (587), SUSAN SEMEREDY (501), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 9, 10, 14, 15, 16, 17, 20, 21, 22, 23, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of nursing and personal care (DONPC), assistant director of nursing and personal care (ADONPC), business manager, environmental services manager (ESM), food service manager (FSM), resident assessment instrument (RAI) coordinator, social worker, admissions coordinator, staff development coordinator, receptionist, families,residents, personal support workers (PSW), registered nursing staff (RN/RPN), laundry aide, food service supervisor (FSS), dietary aides.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_162109_0045	109

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 O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).

s. 241. (12) A licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section. O. Reg. 79/10, s. 241 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that money in the trust account available to resident 41 is in accordance with the instructions of the resident or a person acting on behalf of the resident in respect of property that the resident or person is legally authorized to manage.

Record review and staff interview revealed the resident has his/her money in trust with the home. There is no written authorization for the trust monies provided to the home that specifies what the charges are for, including a description of the goods or services provided, the frequency and timing of the withdrawals.

Interview and record review revealed the home prepared a new trust fund agreement on an identified date when the inspector made the determination that funds were being withdrawn without authority from the resident or a person acting on behalf of the resident. The new agreement was signed by a member of the resident's family and included approval for specified unfunded items. However the trust fund agreement does not include the frequency and timing of the withdrawal and the amount of the charge for the unfunded services that the resident and the resident's family member have signed authorizing deductions from the trust account. [s. 241. (8)]

2. The licensee failed to ensure that the licensee shall not receive, hold or administer the property of a resident in trust other than as provided for in this section.

O.Reg. 79/10 s. 241 (12) has been the subject of a previous compliance order to the licensee with a compliance date of February 14, 2014 (inspection #2013_162109_0045 from January 14, 2014).

Resident 41 was determined to be incapable of managing personal finances on a specified date through a capacity assessment. The assessment was arranged after the resident's power of attorney failed to adequately manage the resident's finances and was not paying the resident's rent.

Staff interview and records review revealed that during a specified date, the home contacted police fraud division to follow up on the fraud investigation that they had previously started. According to the home, there was no response to the home's messages and there has been no further follow up by the home with the police since that time. Interview and records review revealed the home had also been in contact with the Public Guardian's Office up until a specified date. There has been no further attempt by the home to contact the Public Guardian's office. This was confirmed by the Public Guardian's Office and the staff of the home.

Record review and interview with the staff revealed that the resident and his/her family member were asked to sign a Trust Fund Agreement on an identified date when the resident received a sum of money. There was no approval by the POA giving the home permission to charge the trust account for any extra unfunded services.

Review of the resident's trust fund transaction history reveals the resident was charged for an unfunded services. On an identified date, a cheque was paid to the service provider from the home's Resident Trust Account on behalf of resident 41. On another identified date, a receipt had been signed by the resident and not by the POA to pay for a treatment that had been prescribed and was not covered. [s. 241. (12)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On two identified dates, the inspector observed that the door for the laundry chute room on the third floor was unlocked. Registered staff were observed to lock this door on both occasions. Interview with registered staff and the administrator confirmed that this door should be locked at all times as it is unsafe for residents to access the laundry chute. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On an identified date, the inspector observed cobwebs on the walls of the bedroom and dirty marks on the walls and baseboards in the bathroom of room 128. As well, the hallway floor outside this room had large black embedded marks. Interview with the ESM confirmed these areas need cleaning and the floor in the hallway needs to be stripped and waxed.

Review of the home's policy #RCS M-30 titled Equipment Cleaning/Services revised September 20, 2013, revealed that it is the responsibility of the PSWs on the night shift to clean all wheelchairs weekly as per the cleaning schedule using the approved cleaning and disinfection products.

On a specified date, the inspector observed resident #32's wheelchair to be dirty on the arms and underneath the seat. Record review revealed that this wheelchair was not cleaned on a weekly basis as it had not been documented to have been cleaned the weeks of specified dates. Interview with the acting ADONPC confirmed that this wheelchair did not look clean and the home had not been cleaning it on a weekly basis. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the period of a week, the inspectors observed several areas that had not been well maintained:
-Identified resident rooms, common rooms and dining rooms had radiators that are rusty and falling away from the wall;
-A resident's bathroom had stained and broken tiles with toilet grab bars that are corroded at the feet;
-Several walls had been plastered and not painted;
-Second floor shower room in the east wing had an intake vent hanging off of the wall;
-Third floor shower room in the east wing had paint peeling from the ceiling; and
-Second floor common room in the locked unit had the finish from the cupboards peeling off.

Interview with the ESM confirmed that the radiators are to be replaced in the near future, some toilets and tiles need to be replaced, grab bars in an identified resident room needs to be better maintained, painting was not always done in a timely manner, some of the cupboards were slated to be replaced and the intake vent would be put in the

maintenance book for repair. [s. 15. (2) (c)]

3. On a specified date the inspector observed a refrigerator door handle in the second floor servery that was covered in duct tape, which was falling apart and damp. Interview with staff including the acting FSM revealed that this handle had been broken for quite a while. Duct tape had been put on because of the sharp edges and this was a difficult surface to clean and sanitize. The FSM was planning to check with the manufacturer to have the handle replaced. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident abuse of a resident by anyone.

Record review and observation revealed that on an identified date, resident #45 sustained a fractured finger. The resident had been resistive to care during the evening shift as noted in the health record. The progress notes further identified another incident of resistive care with the same caregiver on another identified date, in which the resident scratched and tried to kick the staff member.

Interviews with direct care staff indicated this resident is not normally physically aggressive to care but is frequently resistive to care.

Record review and staff interview revealed that the staff member identified as having had an altercation with the resident was not interviewed by the licensee during the home's internal investigation of the suspected abuse. [s. 23. (1) (b)]

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 appropriate action is taken in response to every alleged, suspected or witnessed incident abuse of a resident by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions.

Record review revealed that on a specified date, resident #32 hit resident #51 on the face. Record review revealed that resident #32 was referred to the psychogeriatric outreach team regarding this incident and one of the interventions recommended was to keep these two residents separated from each other in the hallway and dining room. Record review revealed that the home attempted to relocate resident #32 in the dining room but the resident refused; however, there is no evidence that any attempt was made to relocate resident #51 in the dining room.

The inspector observed that resident #32 and #51 are still seated close to each other in the dining room.

Interview with the registered staff confirmed that keeping these two residents separated in the dining room has not occurred and this could pose a risk for further harmful interactions. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are procedures implemented for addressing incidents of lingering offensive odours.

Throughout the inspection, the inspectors observed that there were strong lingering offensive odours in many of the resident and common area bathrooms. Interview with the ESM confirmed that some bathrooms have the smell of urine embedded in the floor tiles and not until the floor is replaced will the smell be eliminated. [s. 87. (2) (d)]

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 are procedures implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a licensee shall not charge a resident for anything, except if it was provided under an agreement.

Record review and staff interview revealed resident #41 does not have the capacity to manage his/her own finances based on a capacity assessment conducted on a specified date. The capacity assessment was completed when the home had concerns about the legal POA not acting in the best interest of the resident in terms of managing his/her finances. The home had previously contacted the police fraud unit to have the POA investigated for not paying the resident's rent.

Review of the resident trust fund agreement signed by resident #41 and the POA on a specified date, acknowledged a deposit of money. There was no authorization from the resident or a person acting on behalf of the resident to withdraw money for any unfunded services. A withdrawal was made on a specified date from the resident's trust fund for an unfunded service. Another withdrawal was made on another specified date, for medications not covered by Ontario Drug Benefit Plan (ODP). The receipt was signed by the resident who is incapable of managing his/her money, with the administrator signing as the cashier. There was no authorization on the trust fund agreement to take money from the trust fund to pay for medications not covered by ODP. [s. 91. (1) 3.]

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 licensee shall not charge a resident for anything, except in accordance with the following: A resident shall be charged only if it was provided under an agreement, to be implemented voluntarily.

WN #8: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Inspector and an identified PSW observed resident #22 sleeping in bed with 2 quarter siderails up. Interview with identified PSW revealed that resident #22 requires two quarter siderails while in bed. Record review of resident #22's care plan and kardex and in the flow sheet binder indicated that resident requires one quarter siderail up at all times when in bed to assist with positioning. [s. 6. (7)]

2. On a specified date, the inspector observed that resident #52 was served ice cream for dessert at lunch. Record review revealed that the resident is on a nectar thick fluid diet. Interviews with a dietary aide and PSW confirmed that this resident should not have been served ice cream as it is considered a thin liquid and could cause swallowing difficulties for resident #52. [s. 6. (7)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Interview with the ESM revealed that the home evaluates residents' bed systems annually according to best practices.

Interview and record review with the ESM revealed that an evaluation was not completed for resident #26's bed system in 2013. [s. 15. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

Interviews with resident #19 and identified PSW revealed that resident #19 does his/her own oral hygiene. Record review revealed that there is no plan of care to address resident's oral hygiene. [s. 26. (3) 12.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Record review of resident #19's and 20's plan of care and interview with an identified registered staff revealed that neither resident was offered dental assessment and other preventative dental services in 2013. [s. 34. (1) (c)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Residents' Council President and Vice-President revealed that the home does not always respond to the Council within 10 days of receiving concerns or recommendations. Record review revealed that in September of 2014 there were concerns such as nurses taking medication keys when leaving the unit and residents unable to receive medication as needed and popsicles and ice cream were not made available during the hot weather. The meeting was held on September 3, 2014, and the Resident Council President did not receive the response from the home until September 15, 2014. Interview with the Residents' Council assistant confirmed that for this month the Residents' Council was not responded to within 10 days. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a response in writing made within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview with the Family Council President revealed that the home does not respond to the Family Council within 10 days of receiving concerns or recommendations. Record review of the Family Council meeting minutes revealed that many issues identified in the July 3, 2014 meeting were not addressed until September 2014. Interview with the home's Family Council representative confirmed that it has not been the usual practice for the home to respond in writing within 10 days. [s. 60. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' soiled clothes are collected, sorted, cleaned and delivered to the resident.

Record review and staff and resident interviews revealed that resident #20 sent new personal clothing for laundering and resident #30 sent personal clothing for labelling. Interview with the ESM revealed that there was no documentation to show that personal clothing items were returned to these residents. Interview with resident #20 and #30 confirmed that neither resident received their personal clothing back from laundry. [s. 89. (1) (a) (iii)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping, laundry, and maintenance has knowledge of evidence-based practices and/or prevailing practices as applicable.

Interview with the designated lead for housekeeping, laundry, and maintenance revealed that the ESM has been in this position for approximately two and a half years and has not completed any training specific to this role. According to this staff member, she has not yet registered for the Ontario Hospital Association/Ontario Hospitals Housekeepers Association Environmental Services Leadership Module in November 2014, and the course should take six months to a year. [s. 92. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's substitute decision maker (SDM) were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Record review and staff interview revealed that the resident #45's SDM was not notified of the results of the alleged abuse investigation immediately upon the completion. [s. 97. (2)]

Issued on this 4th day of December, 2014

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

Original report signed by the inspector.

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109), JANICE PITTS (587), SUSAN SEMEREDY (501), THERESA BERDOE-YOUNG (596)
Inspection No. / No de l'inspection :	2014_163109_0031
Log No. / Registre no:	T-036-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 20, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	HAWTHORNE PLACE CARE CENTRE 2045 FINCH AVENUE WEST, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Calabrese

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_162109_0045, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 241. (12) A licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section. O. Reg. 79/10, s. 241 (12).

Order / Ordre :

The licensee shall prepare and submit and implement a plan of corrective action including short and long-term strategies and timelines to ensure that the licensee ceases to receive, hold or administer resident #41's property in trust other than as provided for in the regulation.

Please submit compliance plan to susan.squires@ontario.ca by November 28, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that money in the trust account available to resident 41 is in accordance with the instructions of the resident or a person acting on behalf of the resident in respect of property that the resident or person is legally authorized to manage.

Record review and staff interview revealed the resident has his/her money in trust with the home. There is no written authorization for the trust monies provided to the home that specifies what the charges are for, including a description of the goods or services provided, the frequency and timing of the withdrawals.

Interview and record review revealed the home prepared a new trust fund agreement on an identified date when the inspector made the determination that funds were being withdrawn without authority from the resident or a person acting on behalf of the resident. The new agreement was signed by by a

member of the resident's family and included approval for specified unfunded items. However the trust fund agreement does not include the frequency and timing of the withdrawal and the amount of the charge for the unfunded services that the resident and the resident's family member have signed authorizing deductions from the trust account. [s. 241. (8)]

2. The licensee failed to ensure that the licensee shall not receive, hold or administer the property of a resident in trust other than as provided for in this section.

O.Reg. 79/10 s. 241 (12) has been the subject of a previous compliance order to the licensee with a compliance date of February 14, 2014 (inspection #2013_162109_0045 from January 14, 2014).

Resident 41 was determined to be incapable of managing personal finances on a specified date through a capacity assessment. The assessment was arranged after the resident's power of attorney failed to adequately manage the resident's finances and was not paying the resident's rent.

Staff interview and records review revealed that during a specified date, the home contacted police fraud division to follow up on the fraud investigation that they had previously started. According to the home, there was no response to the home's messages and there has been no further follow up by the home with the police since that time. Interview and records review revealed the home had also been in contact with the Public Guardian's Office up until a specified date. There has been no further attempt by the home to contact the Public Guardian's office. This was confirmed by the Public Guardian's Office and the staff of the home.

Record review and interview with the staff revealed that the resident and his/her family member were asked to sign a Trust Fund Agreement on an identified date when the resident received a sum of money. There was no approval by the POA giving the home permission to charge the trust account for any extra unfunded services.

Review of the resident's trust fund transaction history reveals the resident was charged for an unfunded services. On an identified date, a cheque was paid to the service provider from the home's Resident Trust Account on behalf of resident 41. On another identified date, a receipt had been signed by the

resident and not by the POA to pay for a treatment that had been prescribed and was not covered

(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 12, 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 20th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN SQUIRES

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