Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 6, 10, 11, 2011	2011_152_2586_06Jan140523	Critical Incident Log T0013

Licensee/Titulaire
2102677 Ontario Inc. as General Partner for 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 (Formerly Yorkview Lifecare Centre)
2045 Finch Avenue West
North York, ON M3N 1M9

Name of inspector(s)/Nom de l'inspecteur(s)
Susan Squires (109) and Catherine Palmer (152)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspectors spoke with administrator, director of care, assistant director of care, registered staff, personal support workers,

During the course of the inspection, the inspectors reviewed residents' health care records, policies and procedures, staff training binder,

The following Inspection Protocols were used in part or in whole during this inspection:
Responsive Behaviour
Personal Support Services

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

9 WN
7 VPC
2 CO: CO # 001 and CO #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.
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.)	Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 76(7)3 Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Behaviour management.

Findings:

1. The home's staff did not have training in behaviour management in 2010. This was confirmed through a review of the home's staff training manual and staff interviews January 10, 11, 2011.

Inspector ID #:	109 and 152

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O. Reg. 79/10 s. 50(2)(d) Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Findings:

Identified resident was dependant on staff for repositioning.

1. The resident's plan of care stated "turn and reposition as per protocol (Index I.D. G-15)".
2. Staff interviews revealed discrepancies in frequency of turning and repositioning for the identified resident. One registered staff indicated that the resident could reposition himself. One PSW responsible for his care was uncertain as to how often the resident should be repositioned, reporting that he/she was to be repositioned every fifteen minutes or half hour. Another PSW responsible for care on another shift indicated he/she was supposed to be repositioned every hour, but stated that she was not completely sure.
3. There was no "turning and repositioning check sheet" in place for the identified resident as per the home's protocol.

Inspector ID #:	109 and 152

Additional Required Actions:

CO- CO # 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with 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).

Findings:
The licensee failed to protect an identified resident from abuse by his roommate.

Inspector ID #:	109 and 152

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 residents are not abused by anyone to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 6(1)(c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings:
An identified resident plan of care did not set out clear directions to staff and others who provide care.

Inspector ID #:	109 and 152

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 residents written plans of care set out clear directions to staff and others who provide direct care to the resident related to turning and repositioning, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 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:

An identified resident was not turned and repositioned by staff as specified in the plan of care.

Inspector ID #:	109 and 152

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 residents are repositioned according to their plans of care, to be implemented voluntarily.

WN # 6: The Licensee has failed to comply with O. Reg. 79/10 s. 232 Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home.

Findings:
The shift report records were inadvertently removed by the shredding company. .

Inspector ID #:	109 and 152

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 records of the residents are kept at the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O. Reg. 79/10 s. 36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:
1. An identified resident's plan of care stated two staff to turn and reposition while in bed. Two staff did not consistently reposition the identified resident according to the daily care flow sheets and staff interview.

Inspector ID #:	109 and 152

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 staff use safe transferring techniques when positioning residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O. Reg. 79/10 s. 53 (1)2 Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:
An identified resident was identified as having physically and verbally abusive behaviours due to developmental delay and depression.
The identified resident physically assaulted his room mate.

1. Written strategies to respond to an identified resident's responsive behaviours do not include techniques to prevent the responsive behaviour.

Inspector ID #:	109 and 152

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 written strategies to prevent or minimize responsive behaviours are developed for residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O. Reg. 79/10 s. 54(b) 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, identifying and implementing interventions.

Findings:
An identified resident was identified as having physically and verbally abusive behaviours due to developmental delay and depression.
The licensee failed to protect an identified resident from abuse by his roommate.

1. Registered staff from the third floor reported that an identified resident did not typically have a roommate due to his behaviors and poor hygiene.

Inspector ID #:	109 and 152

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

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Cathy Palmer
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). February 14, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspectors:	Susan Squires & Catherine Palmer	**Inspector ID #**	109 & 152
Log #:	T 013		
Inspection Report #:	2011_152_2586_06Jan140523		
Type of Inspection:	Critical Incident		
Date of Inspection:	January 6, 10, 11, 2011		
Licensee:	2102677 Ontario Inc. as General Partner for Rykka Care Centres LP 50 Samor Road, Suite 205 Toronto, ON M6A 1J6		
LTC Home:	Hawthorne Place Care Centre (Formerly Yorkview Lifecare Centre) 2045 Finch Avenue West North York, ON M3N 1M9		
Name of Administrator:	Christine Murad		

To Ontario Inc. as General Partner for Rykka Care Centres LP you are hereby required to comply with the following orders by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)]
Pursuant to: LTCHA, 2007 S.O. 2007 c. 8 s. 76(7)3 Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Behaviour management.			
Order: The licensee shall implement a training program for all staff who provide direct care to residents as a condition of continuing to have contact with residents, training in behaviour management.			
Grounds: 1. The home's staff did not have training in behaviour management in 2010.			
This order must be complied with by:	February 25, 2011		

IO – 08/12 4:20 pm

Ontario

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Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)]

Pursuant to: O. Reg. 79/10 s. 50(2)(d) Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Order: The licensee shall ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Grounds:
Identified resident who was dependant on staff for repositioning, was not repositioned according to his identified condition and need.

This order must be complied with by:	February 25, 2011

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West

Ontario

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Health System Accountability and Performance Division
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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

Toronto, ON
M5S 2T5

Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 03 day of February , 2011.	
Signature of Inspectors:	Catherine Palmer
Name of Inspector:	Susan Squires (109) Catherine Palmer (152)
Service Area Office:	Toronto Service Area Office