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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2013	2012_108110_0033	T-0384-12	Complaint

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 4th, 6th 7th 10th and 11th, 2012

During the course of the inspection, the inspector(s) spoke with Administrator, Food Service Manager and Supervisor, Residents

During the course of the inspection, the inspector(s) Reviewed Resident Council Meeting minutes; observed meal service and staff resident interaction

This inspection related to LOG# T-00384-12

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Residents 1 and 2 were observed not being fully respected in the dining room at lunch on Dec. 4th, 2012 as evidenced by the following:
A resident was served a bowl of soup then minutes later while eating, the bowl was removed without acknowledging the resident. The staff serving stated they had incorrectly served soup to a resident whose diet would not allow for this menu item. The staff member was unable to verify the name of the resident she was serving. The resident was misidentified by the staff and reserved his soup.
Inspector was speaking with an identified resident when a staff member's meal cart bumped into this resident. The resident was not addressed by the staff member.
Random resident interviews revealed that staff do speak rudely at times; staff can be miserable; staff fight with me to get me to do things I do not want to do and one resident stated that they do not feel safe at night in the home. [s. 3. (1) 1.]

2. The following comments were documented in the Resident Council meeting minutes of May and September 2012.
May 2nd, 2012 - "The problem of bullying is still continuing in the dining and front lobby. It must be stopped immediately."
Sept 5th, 2012 - "The lack of respect has to be dealt be immediately." [s. 3. (1) 1.]

3. The following comments were documented in the Food Council meeting minutes of April and June 2012
April 25th, 2012 -"Bullying in the dining room must be dealt with immediately"
June 26th, 2012 - "When residents are asking for staff for something some staff answer back with "this is not my job, ask (name of other person)"."
-"Dining room staff are ignoring residents. example: a resident will ask for something, they won't get a reply from staff but later the staff will bring what the resident asked for." [s. 3. (1) 1.]

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 treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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. Resident Council meeting minutes were reviewed from February 2012 until September 2012. Concerns and recommendations identified were not responded to in writing. An interview with the President of Resident Council and Administrator confirmed that no written response has been provided. [s. 57. (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 within 10 days of receiving advice, responds to the Residents' Council in writing, to be implemented voluntarily.

Issued on this 10th day of January, 2013

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

Diane Brown