



**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

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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
Jan 10, 2014	2013_241502_0006	T- 617/618/620 /626-13	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

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

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

JULIENNE NGONLOGA (502), NITAL SHETH (500)

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): December 13, 16, 17, 2013.

The findings related to non-compliance with s. 3. (1) 3. and s. 3. (1) 2. have been moved to inspection report # 2013_162109_0045.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, registered nursing staffs, maintenance staff, housekeeping staff, Food Service Manager, Social Worker, program staff, Program Director, Environmental Manager, Receptionist, Assistant Director of Care, Acting Administrator.

During the course of the inspection, the inspector(s) reviewed resident's health record, education records on zero tolerance for abuse, mandatory reporting, home's investigation, and related policies.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with.

The home's policy # RCS-10 titled Abuse or Neglect Policy states that all incidents of suspected abuse or neglect must be reported to the Ministry of Health and Long Term Care (MOHLTC).

Record review and staff interview indicates that staff were suspicious on an identified date, that resident #22 was neglected by an identified staff member, when the resident was not provided with adequate personal care after an incontinent episode.

Registered staff documented the critical incident at the end of their shift one day later. The suspicion of neglect was not reported to the Director under the Long Term Care Home Act until 5 days later. The above mentioned home's policy was not complied with. [s. 20. (1)]

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 :



1. The licensee failed to ensure that a person who has reasonable grounds to suspect that alleged or actual abuse or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director under the Long Term Care Act.

Record review and staff interview indicates that staff were suspicious on an identified date, that resident #22 was neglected by an identified staff member, when the resident was not provided with adequate personal care after an incontinent episode. The nurse documented the incident at the end of his/her shift one day later. The Assistant Director of Care became aware of the incident on the same day. The Acting Director of Care became aware 5 days later, and then reported it to the Director under the Long Term Care Home Act on the same day. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,

- (a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
- (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
- (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
- (d) that the changes and improvements under clause (b) are promptly implemented; and
- (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :



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1. The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Staff interview confirmed that the home does not have an evaluation process in place to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (b)]

Issued on this 13th day of January, 2014

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

J. N. Loga.