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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 14, 2014	2013_162109_0045	T-521-13	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

SUSAN SQUIRES (109)

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 10, 11, 16, 17, 18, 2013

Areas of non-compliance from inspection # 2013_241502_0006 which corresponds with log number T- 617-13, T-618-13, T-620-13, & T-626- 13, and inspection # 2013_162109_0042 which corresponds with log T-648-13 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator (acting), Director of Care (acting), Business Manager, Physician, Registered Nursing staff, Personal Support Workers, Residents, Family members.

During the course of the inspection, the inspector(s) conducted walk through of care areas,reviewed the health records for identified residents, observed medication administration system, reviewed trust account processes.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Trust Accounts

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.) 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be treated with courtesy and respect and in a way the fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted.

During a record review of Residents' Council meeting minute's binder, the inspector found an email conversation from an identified date. The email correspondence was based on an inquiry raised by the Residents' Council regarding the new beds being given to some residents and not all residents. The email response included a derogatory statement about the residents who were inquiring about the beds and referring to the residents as not being special and that the residents would get new beds when they stop complaining.

The licensee showed a lack of respect and dignity when the email was included in the minutes for the Residents' Council. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident right to be protected from abuse was respected and promoted.

An interview revealed that, an identified staff member verbally abused Resident # 14 by telling the resident to "shut-up" in response to his/her request to go back to his/her room. An interview with the witness to the abuse revealed the witness observed a staff member placing a clothing protector on Resident # 14's knees. The resident was sitting at the table in the dining room. Resident #14 said "I want to go back to my "F" room. Staff member responded to the resident by saying "Shut-up".

A staff interview confirms the home has conducted an internal investigation of the incident and determined that Resident #14 was verbally abused. The accused staff member was identified, and disciplined according to the home's abuse policy (500) [s. 3. (1) 2.]

3. On an identified date Resident # 2 slid out of the wheelchair and landed on the floor. The nurse upon becoming aware of this fall became frustrated with the resident and grabbed his/her pant leg and shook it and stated out loud "I should quit my job". The Personal Support Workers felt that the nurses actions and words were abusive to the resident and reported their suspicions.
The nurse was suspended for 5 days as the licensee determined that the resident had suffered physical and verbal abuse. [s. 3. (1) 2.]

4. The licensee failed to ensure that Resident #22's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

Staff interview and record review revealed that on an identified date and time, staff found Resident # 22 lying in his/her bed with dried feces on his/her left and right legs, and down to his/her feet; including the bed linen. According to staff, the brief was clean and dry. Resident # 22 was not provided with proper cleansing after the previous incontinent episode (502) [s. 3. (1) 4.]

5. An interview with Resident # 15 revealed that on an identified date and time, a staff member left the resident in his/her bed. Resident #15 stated that at 9:00 am, he/she asked an identified staff member to get him/her out of bed. The staff member told the resident that they will come back and get him/her up. The resident stayed in bed for another 2.5 hours until 11:30 hours when the staff member came to get him/her up.

Resident #15 said, he/she was very hot in bed and felt very uncomfortable.

An interview with the accused staff member revealed that, he/she prefers to get up residents who required less time, first thing in the morning, and leave residents such as Resident # 15, who require more time to get up are left until the later in the morning. The staff member also said to the inspector that Resident # 15 requires two staff assistance and requires a mechanical lift which takes approximately 30-45 minutes.

An interview revealed that, the identified staff member did not attend to the resident from approximately 9:00 am to 12:00 hours in the morning. The resident was referred to the home's Social Worker. During the Social Worker's conversation with Resident # 15, the resident reported that staff went to the resident and said that he/she will return later to get him/her out of his/her bed. However, the resident was left in a bed from 9.00-12.00 hours in the morning. Resident # 15 complained that the room was hot and he/she was sweating in his/her bed.

Interview revealed that the home determined that there was a clear neglect by the staff to the resident and an investigation was initiated.

The Acting Director of Care told the inspector that at the end of his/her investigation the home found that Resident # 15 was neglected by an identified staff and the home disciplined the staff member. (500) [s. 3. (1) 4.]

6. The licensee failed to ensure that Resident # 3's right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference was respected and promoted.

Record review and staff interviews revealed that on an identified date the resident's family member was served with a trespass order from the home advising him/her that he/she had violated the visitor code when there was an altercation between the family member and a nurse. Since this time, the resident has not been allowed to receive visits from the family member.
The resident told the inspector that he/she is depressed and misses his/her family member because he/she used to visit frequently.
A staff member told the inspector that the only way that the resident can visit with the family member is by leaving the property. [s. 3. (1) 14.]

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

Specifically failed to comply with the following:

s. 241. (4) No licensee shall,
(a) hold more than $5,000 in a trust account for any resident at any time; O. Reg. 79/10, s. 241 (4).
(b) commingle resident funds held in trust with any other funds held by the licensee; or O. Reg. 79/10, s. 241 (4).
(c) charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. O. Reg. 79/10, s. 241 (4).

s. 241. (7) The licensee shall,
(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

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 failed to ensure that the licensee does not hold more than $5,000 in a

trust account for any resident at any time.

Review of trust fund balances revealed that there are 5 residents with balances greater than $5,000.
[s. 241. (4) (a)]

2. The licensee failed to provide Resident # 3 or a person acting on behalf of the resident, with a receipt for all money received an deposited into the trust account.
All of resident's income cheques from Canada Pension Plan and Old Age Security are sent directly to the home and deposited into his/her trust account.
In light of the resident having been found incapable of managing his/her finances, the resident or a person acting on behalf of the resident, is not provided with a receipt for these deposits. [s. 241. (7) (a)]

3. The licensee failed to ensure that quarterly itemized statements are provided to Resident # 3 or a person acting on behalf of the resident, for the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds.

Resident # 3 or a person acting on behalf of the resident, has not received any itemized statements from the licensee. This was confirmed through resident and staff interview. [s. 241. (7) (f)]

4. 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.

On an identified date a typed letter written by a staff member, and signed by Resident # 3 indicated that he/she gave the home's staff member consent to discuss his/her Ontario Disability Support Program (ODSP) file.

Two days later a Capacity Assessment revealed that Resident # 3 was incapable of managing his/her own finances. Interview revealed that the licensee had concerns about the management of the resident's finances by his/her family member who was the legal Power of Attorney (POA). The resident's rent was not being paid by the family member and the family member was the billing contact person. According a staff member, the police from the fraud division were involved and suggested that the home look into the resident's capacity. The home decided to arrange for a capacity assessment to be completed for Resident # 3.

After the capacity assessment was completed, the Public Guardian advised the home that they could not take over the resident's file because of the criminal investigation that was underway and because the resident still legally had a Power of Attorney.

On an identified date, which was approximately a month after the resident was deemed to be incapable of managing his/her finances, a typed letter written by a staff member and signed by Resident # 3 was sent to Service Canada giving consent for the staff member to discuss his/her finances and to inform Service Canada that he/she removed his/her family member as Power of Attorney. The letter also stated the resident's wish to change the cheque deposit information to have his/her cheques sent directly to the home.

On an identified date, approximately 6 months afterward, Resident # 3 received a letter from the licensee's Barrister and Solicitor advising the resident that she/he has not been paying for the accommodation, is currently in arrears and that legal action would be taken against the resident to collect the full amount if he/she did not pay within 10 days.

Resident # 3's cheques have been deposited into his/her Trust Fund at the home and the resident's rent is being taken out by the licensee.

As of the date of this inspection, Resident # 3 does not know who is responsible for his/her financial affairs. The home has not followed up with the Public Guardian and Trustee regarding the assessment of incapacity for managing the resident's finances. The home is managing the resident's property. [s. 241. (12)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

Resident # 5 is prescribed a medication to be administered every day at 8:00 am. On an identified date the medication was not administered to the resident until 10:13 a.m.after the resident had the breakfast meal according to the RPN and the electronic signature on the medication administration records. [s. 131. (2)]

2. The licensee failed to ensure that the member of the registered nursing staff who permitted a staff member who is not otherwise permitted to administer a topical only if the staff member has been trained by a member of the registered nursing staff in the administration of topicals; the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and the staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Staff interview revealed that the PSW staff are administering topical medications to the residents. According to the PSW staff, they have not received any training in the administration of the topicals. Furthermore the registered staff member did not know if the PSW's who were administering the topicals were trained or not. The PSW's are not supervised during the administration of the topical medications. [s. 131. (4)]

3. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved the the prescriber in consultation with the resident.

On an identified date and time, the Inspector observed Resident # 5 to have pills and tablets lying loosely on his/her dresser. The resident stated that he/she gets the medications from the nurse and brings them back to his/her room to take them later. Staff interview with the RPN revealed that the resident has not been approved by the physician or other prescriber to keep the drugs on his/her person or in his/her room. [s. 131. (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 drugs are administered to Resident # 5 in accordance with the directions for use specified by the prescriber, and to ensure that no resident administers a drug he himself or herself unless the administration has been approved by the pysician, and to ensure that staff members who are not otherwise permitted to administer a drug to a resident to administer topical unless the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical, to be implemented voluntarily.

Issued on this 14th day of January, 2014

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

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

Ministère 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
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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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2013_162109_0045
Log No. / Registre no:	T-521-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 14, 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 :	Christine Murad

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare and submit and implement a plan of corrective action including short and long-term strategies to ensure that the following rights of residents are fully respected and promoted:

Residents 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.

Resident # 2's right to be protected from physical and verbal abuse.
Resident # 14's right to be protected from verbal abuse.

Resident #22 and # 15's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

The licensee shall facilitate resident # 3's right to communicate in confidence, receive visitors of his/her choice, including the residents family member, and consult in private without interference.

Submit the compliance plan to susan.squires@ontario.ca by January 24, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that every resident's right to be treated with courtesy and respect and in a way the fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted.

During a record review of Residents' Council meeting minute's binder, the inspector found an email conversation from an identified date. The email correspondence was based on an inquiry raised by the Residents' Council regarding the new beds being given to some residents and not all residents. The email response included a derogatory statement about the residents who were inquiring about the beds and referring to the residents as not being special and that the residents would get new beds when they stop complaining.

The licensee showed a lack of respect and dignity when the email was included in the minutes for the Residents' Council. [s. 3. (1) 1.]
(109)

2. On an identified date Resident # 2 slid out of the wheelchair and landed on the floor. The nurse upon becoming aware of this fall became frustrated with the resident and grabbed his/her pant leg and shook it and stated out loud "I should quit my job". The Personal Support Workers felt that the nurses actions and words were abusive to the resident and reported their suspicions.

The nurse was suspended for 5 days as the licensee determined that the resident had suffered physical and verbal abuse. [s. 3. (1) 2.]
(109)

3. The licensee failed to ensure that every resident right to be protected from abuse was respected and promoted.

An interview revealed that, an identified staff member verbally abused Resident # 14 by telling the resident to "shut-up" in response to his/her request to go back to his/her room. An interview with the witness to the abuse revealed the witness observed a staff member placing a clothing protector on Resident # 14's knees. The resident was sitting at the table in the dining room. Resident #14 said "I want to go back to my "F" room. Staff member responded to the resident by saying "Shut-up".

A staff interview confirms the home has conducted an internal investigation of the incident and determined that Resident #14 was verbally abused. The accused staff member was identified, and disciplined according to the home's abuse policy (500) [s. 3. (1) 2.]
(109)

4. An interview with Resident # 15 revealed that on an identified date and time, a staff member left the resident in his/her bed. Resident #15 stated that at 9:00 am, he/she asked an identified staff member to get him/her out of bed. The staff member told the resident that they will come back and get him/her up. The resident stayed in bed for another 2.5 hours until 11:30 hours when the staff member came to get him/her up. Resident #15 said, he/she was very hot in bed and felt very uncomfortable.

An interview with the accused staff member revealed that, he/she prefers to get up residents who required less time, first thing in the morning, and leave residents such as Resident # 15, who require more time to get up are left until the later in the morning. The staff member also said to the inspector that Resident # 15 requires two staff assistance and requires a mechanical lift which takes approximately 30-45 minutes.

An interview revealed that, the identified staff member did not attend to the resident from approximately 9:00 am to 12:00 hours in the morning. The resident was referred to the home's Social Worker. During the Social Worker's conversation with Resident # 15, the resident reported that staff went to the resident and said that he/she will return later to get him/her out of his/her bed. However, the resident was left in a bed from 9.00-12.00 hours in the morning. Resident # 15 complained that the room was hot and he/she was sweating in his/her bed.

Interview revealed that the home determined that there was a clear neglect by the staff to the resident and an investigation was initiated.

The staff member told the inspector that at the end of his/her investigation the home found that Resident # 15 was neglected by an identified staff and the home disciplined the staff member. (500) [s. 3. (1) 4.]
(109)

5. The licensee failed to ensure that Resident #22's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

Staff interview and record review revealed that on an identified date and time, staff found Resident # 22 lying in his/her bed with dried feces on his/her left and right legs, and down to his/her feet; including the bed linen. According to staff,

the brief was clean and dry. Resident # 22 was not provided with proper cleansing after the previous incontinent episode (502) [s. 3. (1) 4.]

(109)

6. The licensee failed to ensure that Resident # 3's right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference was respected and promoted.

Record review and staff interviews revealed that on an identified date the resident's family member was served with a trespass order from the home advising him/her that he/she had violated the visitor code when there was an altercation between the family member and a nurse. Since this time, the resident has not been allowed to receive visits from the family member.

The resident told the inspector that he/she is depressed and misses his/her family member because he/she used to visit frequently.

A staff member told the inspector that the only way that the resident can visit with the family member is by leaving the property. [s. 3. (1) 14.]
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

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 cease to receive, hold or administer Resident # 3's property in trust other than as provided for in the regulation.
The licensee shall facilitate actions to ensure that Resident # 3's financial affairs are being managed by the appropriate Trustee and not by the licensee.
The licensee shall communicate this information to resident # 3 upon completion of these arrangements.

Grounds / Motifs :

1. 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.

On an identified date a typed letter written by a staff member, and signed by Resident # 3 indicated that he/she gave the home's staff member consent to discuss his/her Ontario Disability Support Program (ODSP) file.

Two days later a Capacity Assessment revealed that Resident # 3 was incapable of managing his/her own finances. Interview revealed that the licensee had concerns about the management of the resident's finances by his/her family member who was the legal Power of Attorney (POA). The resident's rent was not being paid by the family member and the family member was the billing contact person. According a staff member, the police from the fraud division were involved and suggested that the home look into the resident's capacity. The home decided to arrange for a capacity assessment to be completed for Resident # 3.

After the capacity assessment was completed, the Public Guardian advised the home that they could not take over the resident's file because of the criminal investigation that was underway and because the resident still legally had a Power of Attorney.

On an identified date, which was approximately a month after the resident was deemed to be incapable of managing his/her finances, a typed letter written by a staff member and signed by Resident # 3 was sent to Service Canada giving consent for the staff member to discuss his/her finances and to inform Service Canada that he/she removed his/her family member as Power of Attorney. The letter also stated the resident's wish to change the cheque deposit information to have his/her cheques sent directly to the home.

On an identified date, approximately 6 months afterward, Resident # 3 received a letter from the licensee's Barrister and Solicitor advising the resident that she/he has not been paying for the accommodation, is currently in arrears and that legal action would be taken against the resident to collect the full amount if he/she did not pay within 10 days.

Resident # 3's cheques have been deposited into his/her Trust Fund at the home and the resident's rent is being taken out by the licensee.

As of the date of this inspection, Resident # 3 does not know who is responsible for his/her financial affairs. The home has not followed up with the Public Guardian and Trustee regarding the assessment of incapacity for managing the resident's finances. The home is managing the resident's property. [s. 241. (12)] (109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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.

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

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 14th day of January, 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