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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Apr 10, 2014;	2013_237500_0006 (A2)	T-238/245/654-13	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

NITAL SHETH (500) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The following WN has been amended to read as the following:

WN #3: 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 failed to ensure that 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.

An interview with previous vice President and President of the Residents' Council revealed that the home is not providing written responses to each concern raised by the Resident's Council within 10 days.

A review of Residents' Council meeting minutes for an identified period indicates that residents raised concerns regarding smell of urine in the washrooms, cracks in the cups and plates and residents requested for the older songs in Karaoke program. A review of Residents' Council meeting minutes for an identified period indicates that residents raised concerns about not receiving popsicles on an identified floor on a hot day, some residents not receiving evening snack in certain areas on an identified floor, residents not using ashtrays while smoking and throwing cigarettes on the ground, residents are not smoking in the designated areas and close to the entrance.

Record review and staff interview confirmed that the home have not provided written response to the Residents' Council for above raised concerns by the Residents' Council within 10 business days. [s. 57. (2)] (500)

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 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, to be implemented voluntarily.

Issued on this 10 day of April 2014 (A2)

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

Nital Sheth

Ontario

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

NITAL SHETH (500) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 28, 29, December 2,3,4,5,6,9,10,11,12, 2013.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Nursing staff, maintenance staff, housekeeping staff, program staff, Program Director, Environmental Manager, receptionist, Assistant Director of Care, acting Administrator.

During the course of the inspection, the inspector(s) reviewed the policy on Resident's Council, Resident's Councils' meetings minutes, observed dining room, observed TV lounge, observed residents participating in activities, reviewed employment records and related policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Dining Observation

Nutrition and Hydration

Recreation and Social Activities

Reporting and Complaints

Residents' Council

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care of resident # 6 is provided to the resident as specified in the plan.

Resident # 6's plan of care states that he/she will be invited to participate in an identified activity. A record review and staff interview confirmed that an identified activity is offered weekly on an identified day to resident # 6, however resident # 6 was not invited to participate in an identified activity in the past quarter as indicated in the plan of care. The care set out in the plan of care was not provided to resident # 6 as specified in the plan. [s. 6. (7)]

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

Resident # 20's plan of care, instructed staff to provide resident with an identified diet, regular texture. On December 5, 2013 lunch service time was observed by an inspector. Observations and staff interviews revealed that resident # 20 was not offered the home's identified diet as specified in the resident care plan. The resident was provided cream of mushroom soup by the home. Staff and resident interviews confirmed that the resident is offered only soup without entrées at lunch meal services on a regular basis. [s. 6. (7)]

3. The licensee failed to ensure that resident # 19 is reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident # 19's plan of care indicates that the resident requires an identified diet, regular texture, and regular thin fluids. Resident interview confirmed that his/her

dietary needs have changed due to regular milk intolerance.

Record review revealed that resident # 19 has complained on an identified day that regular milk hurts his/her stomach. Registered staff provided a lactaid (lactose free milk) to the resident for a trial, and resident did not report symptoms of stomach discomfort. On an identified day a dietary referral was made to assess resident # 19 for regular milk intolerance. A record review and staff interview revealed that resident # 19 has not been reassessed for regular milk intolerance until 12 days later and the plan of care was not reviewed and revised when resident's care needs changed. [s. 6. (10) (b)]

4. The licensee failed to ensure that resident # 20 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan is no longer necessary.

Record review indicates that resident # 20 had requested for rice with curry and fried egg every day at lunch and dinner. A review of nutrition's progress notes indicate that Registered Dietitian met with the resident and her/his family to reassess resident and address concerns related to food preferences raised by the resident. In an interview, the Registered Dietitian stated that he/she has completed the quarterly assessment, however he/she was not been able to transfer his/her assessment notes and update the care plan.

Resident # 20's plan of care instructed staff to provide resident with an identified diet, regular texture no food preferences indicated, despite the noted change in his/her food preferences. The care plan was not revised to reflect the change in resident's dietary preferences. [s. 6. (10) (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 care set out in the plan of care of residents # 6 and # 20 is provided to the resident as specified in the plan, and that resident # 19 and # 20 are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that call bells are easily accessed and used by resident # 18 and resident # 23 at all times in their rooms.

On an identified day, resident # 18 was observed lying in his/her bed. The resident indicated that he/she was lying there since breakfast. He/she stated that he/she was tired waiting to get out, and use the toilet. The resident was not able to reach for the bell to call for help. [s. 17. (1) (a)]

2. On an identified day, resident # 23 was observed lying in his/her bed. The call bell was not within his/her reach. Staff interview confirm that the call bell should be clipped on the bed sheet. Following the provision of care, the call bell was not placed within the resident's reach for the second time on the same day. After the inspector notified the staff that the resident could not reach the call bell, the staff placed the call bell within the resident's reach. [s. 17. (1) (a)]

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 call bells are easily accessed and used by the residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that 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.

An interview with previous vice President and President of the Residents' Council revealed that the home is not providing written responses to each concern raised by the Resident's Council within 10 business days.

A review of Residents' Council meeting minutes for an identified period indicates that residents raised concerns regarding smell of urine in the washrooms, cracks in the cups and plates and residents requested for the older songs in Karaoke program. A review of Residents' Council meeting minutes for an identified period, indicates that residents raised concerns about not receiving popsicles on 3rd floor on a hot day, some residents not receiving evening snack in certain areas on 3rd floor, residents not using ashtrays while smoking and throwing cigarettes on the ground, residents are not smoking in the designated areas and close to the entrance.

Record review and staff interview confirmed that the home have not provided written response to the Residents' Council for above raised concerns by the Residents' Council within 10 business days. The acting administrator has provided only one written response given on an identified day to the Residents' Council for another concern. [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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee did not ensure that after receiving a verbal complaint from a resident, that it was investigated and resolved where possible and that the resident received a response within 10 days of making the complaint.

Resident # 5 reported that he/she made several verbal complaints to staff about the smell of tobacco entering his/her room over the course of 2 years. The resident did not receive any response from management staff as to their course of action to resolve the odours. The resident stuffed newspapers under the door in the bathroom. Staff who cared for the resident and who cleaned the room were interviewed and reported that they were aware of the resident's concerns and were aware of the fact that the resident stuffed newspapers under a door in their bathroom. Neither of the staff members reported the concern to their superiors. A registered staff member recalled that she contacted maintenance staff in 2012 and made them aware of the resident's concern, however the individuals were no longer employed in the home to offer any statements as to their course of action. The current environmental services supervisor was not aware of the issue. During the inspection, the resident's bathroom was observed to have newspapers stuffed under a secondary door, which connects the bathroom to the equipment room for the smoking room. The equipment room was directly connected to the vestibule which is a preliminary entry point to the smoking room. The equipment room door was found wide open. At the time of inspection, no odours were detected as no smokers were in the smoking room. [s. 101. (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 written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follow: the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that the home furnishings are kept clean and sanitary.

The inspector observed food stains on an identified number of chairs in third floor and first floor dining room.

An interview with housekeeping staff revealed that dining room chairs are covered with fabric and required deep cleaning.

An interview with the Environmental Service Manager identified the need to replace dining room chairs as those chairs are covered with fabric, and the stains are not removed by steam cleaning. The home is planning to replace all dining room chairs by end of next year. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 64. s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of Residents' Council only if invited.

An interview with the previous president of the Residents' Council revealed that program staff who brought residents to attend Resident's Council meetings usually stay during the meetings. The council has never provided permission for program staff to attend the meetings.

An interview with Environmental and Service Manager revealed that usually first floor program staff stays in the Residents' Council meeting in case something happens or anyone requires to leave the room.

Staff confirmed in their interviews that one or two staff members stay during Residents' Council meetings for emergency purpose in case if something happens to the residents to ensure their safety. [s. 64.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 20 is offered a minimum of three meals daily.

Resident # 20's written plan of care indicates staff to provide an identified diet, regular texture. Staff interview revealed that resident is only offered soup at lunch. Resident interview and inspector's observation confirmed that resident eats lunch and dinner brought by the family on a daily basis and he/she did not receive three meals on a daily basis. [s. 71. (3) (a)]

2. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

The inspector observed on an identified day at lunch service, the planned dessert was not offered to the residents. The planned menu posted on each floor indicated chocolate brownie for one of the dessert choices, however resident's were offered banana cake. On an another identified day at lunch service the planned menu indicated cheese on pumpernickel bread, however residents were served cheese on rye bread.

An interview with Food Service Supervisor revealed that the Food Service Manager was on vacation, therefore chocolate brownie and pumpernickel bread were not ordered and the menu had to be changed. [s. 71. (4)]

3. The licensee failed to ensure that an individualized menu is developed for resident # 20 whose needs cannot be met through the home's menu cycle.

A review of resident # 20's plan of care indicates resident requires an identified diet, regular texture and has poor food intake since admission. The resident has requested for the cultural foods rice, curry and fried eggs everyday. An interview with the Registered Dietitian revealed that, with a consent of resident and family, the home agreed to provide rice, curry and fried egg on alternate days. The registered dietitian confirmed that an individualized menu to meet resident # 20's cultural food preferences was not developed by him/her at any point. [s. 71. (5)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must, at a minimum, provide for, communication to residents and staff of any menu substitutions.

The inspector observed on an identified day at lunch service, the planned dessert was not offered to the residents. The planned menu posted on each floor indicated chocolate brownie for one of the dessert choices, however resident's were offered banana cake. The posted menu was not changed and the substitution was not communicated to the residents. On an another identified day at lunch service, the planned menu indicated cheese on pumpernickel bread, however residents were served cheese on rye bread. The inspector observed one of the dietary staff changing menus on the boards at the time when almost half of the meal service was completed. Menu substitutions were not communicated to the residents prior to the meal service.

An interview with Food Service Supervisor revealed that the Food Service Manager was on vacation, and due to lack of time he/she was not able to change menu on board for substitutions. [s. 72. (2) (f)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

The home requires a nutrition manager on site working 78.4 hours per week, based on 97 per cent or less. A record review revealed that the home provided 40.0 hours per week during the an identified period.

An interview with the Food Service Manager and Acting Administrator confirms a short fall of 38.4 hours per week during the an identified period. [s. 75. (3)]

(A1)
The following Non-Compliance has been Revoked: WN #6

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (1) Every licensee of a long-term care home shall ensure that a Residents' Council is established in the home. 2007, c. 8, s. 56 (1).

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

Nital Sheth.