Ontario

**Ministry of Long-Term Care**

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

**Ministère des Soins de longue durée**

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 22, 2020 | 2020_826606_0008 | 023034-19, 001777-20 | Complaint |

### Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

### Long-Term Care Home/Foyer de soins de longue durée

Cooksville Care Centre
55 The Queensway West MISSISSAUGA ON L5B 1B5

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

JANET GROUX (606)

## 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): February 24, 25, 27, 28, March 3, and 4, 2020.**

**The following Complaint Intake was inspected:**
**Concerns regarding the home's food quality, housekeeping, pest control, a resident's plans of care and a concern regarding a resident's personal support services in regards to the resident's hygiene and grooming, handling of the resident's hearing aid, and laundry services.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Directors of Care (CDOC), Business Manager, Social Worker (SW), Patient Flow Coordinator, Staffing Clerk, Environmental Services Manager, Registered Nurses (RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), PSW Student, Housekeeping, Laundry Aide, Dietary Aide, Substitute Decision Makers (SDM), and residents.**

**The inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plans of care, reviewed relevant home's investigation records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Food Quality**
**Personal Support Services**
**Sufficient Staffing**
**Trust Accounts**

**During the course of this inspection, Non-Compliances were issued.**
**3 WN(s)**
**0 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident was reassessed and if the plan of care was being revised because care set out in the plan had not been effective, that the licensee considered different approaches.

A complaint submitted to the Ministry of Long Term Care (MLTC) alleged the Home lost resident #001's hearing aid.

Resident #001's progress notes stated the resident's hearing aid was reported missing on an identified date. PSW #108 acknowledged the hearing aid was still missing.

Resident #001's progress notes showed documentation on identified dates that resident #001 exhibited a specific behaviour related to their hearing aid. The progress notes did not show any follow up to address and prevent the potential risk of the hearing aid from going missing due to the resident's behaviour.

The plan of care directed staff to follow a specific process related to the hearing aid. RPN #107 acknowledged this and said this intervention had been in place for a long time.There was no evidence that showed additional or different approaches were tried to prevent the risk of the resident's hearing from going missing due to their behaviour.

The Director of Care (DOC) acknowledged that when interventions in the plan of care were not working, the expectation was for the team to collaborate with each other to come up with alternatives and strategies to find an effective solution to the problem.

The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised and if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident have their personal items, including personal aids such hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

A complaint submitted to the MLTC alleged the Home lost resident #001's hearing aid.

The Long Term Care Homes (LTCH) Inspector observed on an identified date resident's #010's hearing aid was not labelled. RPN #120 acknowledged this.

The licensee has failed to ensure that resident #010's hearing aid was labelled. [s. 37. (1) (a)]

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**WN #3: 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. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that they have not held more than $5,000 in a trust account for any resident at any time.

A Complaint submitted to the MLTC alleged the Home directed resident #002 to take away resident #002's Substitute Decision Maker (SDM) from having authorization to the resident's government funds.

Resident #002's progress notes on an identified date documented that the resident requested their money to be moved to the trust account in their home. SW #123 acknowledged this.

The resident's Trust Statement on an identified date stated an identified balance. The Business Manager said the resident exceeded the balance that they were allowed to have in their Trust Account and acknowledged that they were in non compliance with the regulations.

The licensee has failed to ensure that they have not held more than $5,000 in a trust account for resident #002 at any time. [s. 241. (4) (a)]

2. The licensee has failed to ensure that the licensee received written authorization from the resident, who wished to pay a licensee for charges under section 91 of the Act with money from a trust account, that specified what the charge was for including: a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge.

Resident #002's trust account showed an identified payment was debited from the trust account on identified dates. There was no document to demonstrate that resident #002 authorized the Home to withdraw any money from their trust account.

The Business Manager and SW #123 confirmed that a document was not signed as required by resident #002 when they began withdrawing the resident's accommodation fees on an identified date.

The licensee has failed to ensure that the licensee received written authorization from resident #002, to pay a licensee for charges under section 91 of the Act with money from a trust account. [s. 241. (8)]

**Issued on this 29th day of May, 2020**

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

**Original report signed by the inspector.**