



**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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**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|------------------------------------------------|-----------------------------------------------|--------------------------------|----------------------------------------------------|
| Dec 6, 2013                                    | 2013_162109_0032                              | T-1-13                         | Complaint                                          |

**Licensee/Titulaire de permis**

**TORONTO LONG-TERM CARE HOMES AND SERVICES  
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6**

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

**CAREFREE LODGE  
306 FINCH AVENUE EAST, NORTH YORK, ON, M2N-4S5**

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

**SUSAN SQUIRES (109), 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): August 26, September 17, October 15, November 28, 2013**

**During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care, Registered Staff, Food Service Supervisor, Dietitian, cook, Family members, residents, Personal Care Attendants**

**During the course of the inspection, the inspector(s) Conducted a walk through of the care areas, observed meal service, reviewed health records for identified residents, reviewed policies**

**The following Inspection Protocols were used during this inspection:**

**Nutrition and Hydration**
**Resident Charges**

**Findings of Non-Compliance were found during this inspection.**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

| Legend                                                                                                                                                                                                                                                                  | Legendé                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order                                                                                                                     | 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.) | 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. 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:**

**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).**



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**Findings/Faits saillants :**

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1. The licensee failed to ensure that the residents right to be properly fed and cared for in a manner consistent with his or her needs was fully respected and promoted for resident #1 and resident # 2.

Carefree Lodge, the home of residents #1 and #2, failed to operate as a place where residents #1 and #2 have their spiritual and cultural needs adequately met.

Resident #1 was admitted to the home on an identified date. The admission assessment identified resident #1 as a particular creed requiring him/her to have specialized foods as part of his/her religious observance.

Family and staff interviews confirmed that at the time of resident #1's admission the family was aware that the specialized food was not available in the home and that family were expected to make arrangements to bring in foods at the resident/family expense.

Resident #1's Power of Attorney (POA) arranged to have the specialized foods delivered at a cost of approximately \$6.37 for each meal that he/she purchased. Resident's POA arranged to be brought to and from the LTC home every day with the resident's specialized food except for certain days in which he/she would arrange to have someone else go to the home and provide the resident with the specialized meal. The POA of resident #1 told the inspectors that he/she knew that the home did not have the particular specialized food but that he/she was in a desperate state because the resident required crisis placement into the home. Resident #1's POA stated he/she felt that he/she had no other choice since there were no vacancies in other homes that provide particular specialized foods. Resident #1's POA stated that he/she continued with this process while the resident stayed in the home for a specified period of time. However on a specified date resident # 1's POA discharged the resident because a religious observance was coming and he/she didn't know what else to do because he/she stated that it would have been a nightmare trying to be at the home for the resident during this religious period.

The interview with the licensee revealed that the home did not provide the specialized meals for Resident #1 because they do not have the proper system for storing, handling and preparing the food. The licensee stated that the POA of this Resident made the arrangements to have the specialized foods purchased outside of the home and they served the food to the Resident. [s. 3. (1) 4.]



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2. Resident # 2 was admitted to the home on an identified date. An interview with the family member revealed resident # 2 to be of a strict creed and very religious his/her entire life and that meals were an issue for the resident. The admissions Spiritual and religious care assessment identifies this resident is of a specified faith and requires a special diet based on his/her religion. The initial care conference held on an identified date with the administrator present indicates that the family were told that they were not able to offer specialized foods to the resident and referred the family to an outside agency to coordinate for meals to be purchased and brought in for the resident. An interview with the family member revealed that the resident's family were not able to purchase specialized meals for every meal due to the high cost and their personal financial hardship and inability to pay. [s. 3. (1) 4.]

***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 the residents right to be properly fed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

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

**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).**

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**Findings/Faits saillants :**



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1. The licensee failed to ensure that an individualized menu is developed for each Resident whose needs cannot be met through the home's menu cycle.

Resident #1 was admitted to the home on a specified date and is of strict identified creed requiring specialized foods as part of his/her religious observance. Resident #1's plan of care was developed by the Registered Dietitian. The individualized menu was incomplete because the family was left to provide oatmeal at breakfast and an unspecified specialized soup and entree at lunch and dinner to meet resident #1's spiritual needs.

Resident #1's POA stated that he/she continued with this process while the resident stayed in the home for a specified period of time. Resident #1's family discharged him/her on an identified date related to the need to observe the upcoming religious period and the associated challenges of providing specialized meals to Resident # 1 in the home [s. 71. (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 an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges**

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

**s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).**

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**Findings/Faits saillants :**



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1. The licensee failed to ensure that the licensee shall not cause or permit anyone to make a charge or accept a payment on the licensee's behalf that the licensee is prohibited from charging for under the legislation.

Resident #1 lived in semi-private accommodation and resident #2 is currently living in basic accommodation at Carefree Lodge. Both residents are of strict particular creed, requiring specialized foods as part of their religious observance. The Long-term Care Home (LTCH) does not have a specialized kitchen and staff interviews revealed that the LTCH will not order or pay for specialized food to be brought in to the home.

Family and staff interviews confirmed that both residents were required to pay for specialized meals brought to home by their families. Furthermore interviews revealed that concerns of the family of resident #2's inability to pay up to \$7.75 per meal plus tax and delivery costs were shared with the home's administrator.

Correspondence from the Administrator to Resident #2's family indicated that the home was not prepared to cover any costs and offered a solution whereby family should contact an external organization to discuss their issue of financial hardship related to the on-going costs of purchasing specialized meals.

Both families of Resident #1 and #2 requested compensation or subsidization of the cost of specialized meals from the licensee. Financial compensation was not provided.

Resident #1's family discharged him/her on an identified date related to the need to observe the upcoming religious period and the associated challenges with leaving Resident #1 in the home during the religious period. [s. 91. (4)]

***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 the licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under the legislation and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf, to be implemented voluntarily.***



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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to the residents at all times.

The inspector observed shower and tub room doors to be propped open with a washcloth placed along the top of the door, which prevented the door from closing and locking. Inside the door, accessible to residents, was a hazardous substance labeled as a chemical detergent/disinfectant N-456.

This was observed on the following areas:

Shower room on first floor across from room 113.

Shower Room 237 on 2nd floor.

Shower room 226. [s. 91.]

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**Issued on this 12th day of December, 2013**

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

A handwritten signature in black ink, appearing to be "J. Spence", written over a white background within a rectangular box.