



**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**

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

**Division des foyers de soins de
longue durée
Inspection de sions de longue durée**

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 6, 2016	2016_356618_0006	003248-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): March 7,8,9, 2016

**This inspection was conducted concurrently with Resident Quality Inspection #
004698-16.**

**During the course of the inspection, the inspector(s) spoke with personal support
workers (psw), registered staff, Assistant Director of Care (ADOC) and resident's
family.**

**During the course of the inspection, the inspector conducted record review and
observations of resident and the resident's home area.**

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

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**

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.O. 2007, c.8, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review revealed that on December 30, 2015 Resident #001 incurred an injury to an identified part of the body while using the toilet.

Review of resident's plan of care and assessments revealed that this resident required extensive assistance with all activities of daily living and that they were assessed as being a high risk for falls.

Interview with staff #113, Assistant Director of Care (ADOC) revealed that the expectation for all residents requiring extensive assistance and with a high fall risk is that they have constant supervision while being toileted.

Interview with psw, staff #100 revealed that they had left resident unattended on the toilet while they left to get the resident's denture cup from resident's bedside. They heard the resident call out from the wash room and returned to find the resident in a half standing position with the identified injury and blood markings on the hand rail to the right of the toilet.

Interview with staff #113, ADOC confirmed that the plan of care had not been followed for this resident. [s. 6. (7)]



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Issued on this 6th day of April, 2016

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

Original report signed by the inspector.