



**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 soins de longue durée**

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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
May 26, 2016	2016_356618_0014	027136-15	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): May
9,10,11,12,13,16,17,18,19, 2016.**

**This complaint inspection was related to Resident plan of care, elopement, billable
and accommodation charges and dealing with complaints.**

**During the course of the inspection, the inspector(s) spoke with Registered Nurse
(RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Director
of Care (DOC).**

**During the course of the inspection, the inspector conducted observations of the
Resident and Resident's home area, and conducted review of Resident's health
records.**

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
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	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
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

- 1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).**
- 2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**
- 3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**
- 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**
- 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**
- 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible regarding a missing resident who returned to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

Record review and staff interview revealed that Resident #001 eloped from the home and returned in under three hours with an injury.

Registered staff #101 revealed that at 1325 hours they were informed by Police that Resident #001 was in the care of the Police at the plaza across the road from the home.

Staff #101 accompanied by another staff member went to retrieve the Resident and were told by Police that the resident had fallen.

Staff #101 observed an injury to an identified body part.

Staff #101 confirmed that Resident #001 had attended lunch in the dining room that day and determined that the Resident had left the home at approximately 1300 hours. The Resident was not known to exhibit exit seeking behaviours.

Interview with Director of Care (DOC) confirmed that the elopement had occurred and that the Resident #001 had returned with an injury and that the Director had not been informed. [s. 107. (1)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.