

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	•	Type of Inspection / Genre d'inspection
Jan 2, 2013	2012_108110_0038	T-594-12	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

DIANE BROWN (110), VALERIE JOHNSTON (202)

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): December 4th, 6th, 7th, 10th, 11th, 18th, 2012

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), Dietitian (RD), Registered Staff, Social Worker, Food Service Supervisor, Food Service Workers, Personal Support Workers.

During the course of the inspection, the inspector(s) Observed the provision of care to resident; reviewed residents' health record, relevant policies and procedures and the homes' menu.

This inspection related to LOG #T-594-12

The following Inspection Protocols were used during this inspection: Dignity, Choice and Privacy Nutrition and Hydration Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NO	N - RESPECT DES EXIGENCES
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction	WN – Avis écrit VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
	CO – Ordre de conformité WAO – Ordres : travaux et activités
CO – Compliance Order WAO – Work and Activity Order	CO – Ordre de conformité



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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 nonrespect 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4). (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants:



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1. Resident A's plan of care identified this resident at high nutritional risk related to poor intake and significant unplanned weight loss. Residents plan of care includes a December 29th, 2011 Physician order to "monitor weight Q 1 week". According to the residents health record nursing staff transcribed the order to "monitor weight x 1 week".

Resident A's weight had been taken on December 9th, 2011 and the next routine monthly weight was taken January 6th, 2012. Weights continued to be taken monthly. No changes to weight monitoring resulted from the December 29th, 2011 Physician order. Resident A continues to lose weight. An interview with the ADOC revealed that the intent of the order was probably "weekly weights" and nursing staff should have clarified the order with the Physician. [s. 6. (4) (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 staff and others involved in the different aspects of care of the resident collaborate with each other., to be implemented voluntarily.

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).

Findings/Faits saillants:



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Resident A's plan of care identifies residents at high nutritional risk; severely underweight status with BMI of 17.9; significant and ongoing weight loss and poor intake related to dislike of the homes' food. Resident A is known to the home to prefer specific foods based on a religious preference. Foods of this nature are not available in the home. Resident relies on family to provide lunch and supper meals. An interview with the registered dietitian (RD) confirmed that the home relies on food brought in by the family. The RD is not aware of the foods being provided by family and whether resident's nutritional needs are being met Resident A does not have an individualized menu to meet his nutritional needs and religious preference. [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 Resident A is provided an individualized menu, to be implemented voluntarily.

Issued on this 10th day of January, 2013

Siane Brown

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

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