Ontario

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
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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
Dec 31, 2013	2013_237500_0005	T-382-13	Critical Incident System

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

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 27, 28, 29, 2013

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Nursing Staff, Assistant Director of Care, Acting Administrator

During the course of the inspection, the inspector(s) conducted record review, observations, policy reviews

The following Inspection Protocols were used during this inspection:

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Critical Incident Response
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 6 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

An interview conducted with the registered staff revealed that resident # 6 is deteriorating in his/her condition and currently using a wheel chair. The resident requires total assistance and the staff to wheel the chair.

The inspector observed that there is a wander guard placed on resident's walker and the walker is folded and stored in resident's bedroom closet.

Staff interview confirmed that resident # 6 required a wander guard and placed on every 15 minutes of observation, when resident had wandering and exit seeking behaviour.

A review of current care plan for resident # 6 indicates that resident # 6 is at risk of elopement and interventions indicate that the resident is on every 15 minute continuous observation, wander guard placed on his walker.

Based on the information mentioned above resident # 6's care plan was not reviewed and revised when care set out in the plan of care was not necessary, when resident # 6's care needs changed and care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

Issued on this 31st day of December, 2013

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

Nital