



**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
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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
Feb 6, 2013	2013_190159_0003	H-001782- 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

**COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5**

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

ASHA SEHGAL (159)

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): January 16, 18, 22, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director Of Care, Food Service Manager, Personal Care Aides(PCA), Dietary Staff, Registered Practical Nurses, Registered nurses and residents.

During the course of the inspection, the inspector(s) Observed breakfast and noon meal service in the main dining room, reviewed medical records and plans of care for identified residents, reviewed Resident Council meeting notes and the menus.

The following Inspection Protocols were used during this inspection:

Dining Observation

Food Quality

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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 non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :



1. The licensee did not ensure that dining and snack service included monitoring of all residents during meals.

At breakfast meal on January 22, 2013 in the main dining room a number of residents were observed to be not present in the dining room for breakfast and their beverages were set up at the table. Interviewed staff confirmed Personal Care Aides (PCA) were assigned to bring the residents to the dining room for breakfast and missing residents were from third floor.

The breakfast meal commenced at 0850 hours. There was an observed wait of long periods for residents' to have their meals. Three residents were noted to be leaving dining room prior to being served main course. The dining service did not have a system for monitoring of the residents eating in the dining room and the delivery of meals. [Reg. 79/10, s. 73(1) 4 [s. 73. (1) 4.]

2. Sufficient time for every resident to eat meal at his or her space was not provided.

January 22, 2013 breakfast meal did not start at scheduled time of 830 hours.

Residents were observed receiving first course i.e. hot cereal at 0910 hours. Resident Council meeting minutes for July 2012 were reviewed and indicated that the residents had voiced concerns regarding meals not served on scheduled time and that breakfast was always served late. Interviewed staff and residents confirmed the meal service is often late, does not allow sufficient time for dining and that residents are rushed. [s. 73. (1) 7.]

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 home has a dining and snack service that includes monitoring of all residents during meals; sufficient time for every resident to eat at his or her space is provided, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production



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Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the production system were prepared, stored and served using methods to preserve nutritive value, appearance and food quality.

During the inspection a number of residents expressed numerous concerns and issues regarding quality of juice served. January 18, 2013 the choice of apple juice served at lunch lacked flavour, colour and taste. The inspector tasted the apple juice and found the juice lacked flavour of apple with a high concentration of sugar. The colour of the juice was very pale and watery in appearance. [Reg. 79/10, s. 72(3)(a)] [s. 72. (3) (a)]

Issued on this 11th day of February, 2013

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

ASHA SENGAL