Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 26, 2020	2020_754764_0008	020014-19, 011677-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

NAZILA AFGHANI (764), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Onsite on: June 11, 12, 15, 16, 17, 18, 19, and 23, 2020. Offsite inspection on: June 24, 2020.

Logs #011677-20, and 020014-19 related to housekeeping services and prevention of abuse and neglect were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Environmental Service Manager (ESM), Hospital Regional Directors of Operations, Hospital Manager of Housekeeping, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident rooms were terminally cleaned during the COVID-19 outbreak in the home.

This inspection was initiated related to two complaints from a resident, received by the Ministry of Long-Term Care (MLTC) related to no terminal cleaning being done, after the death of residents.

During interview with resident / complainant, they stated that residents who they shared a room with, passed away, and the room was not cleaned. Resident stated although daily cleaning occurred, the proper deep cleaning was not done until a month later.

Review of progress note indicated that ADOC was notified by resident about their concern.

Review of Public Health Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018, indicated the following points:
- Page 14- Discharge/transfer cleaning: The thorough cleaning of a client/patient/resident room or bed space following discharge, death or transfer of the client/patient/resident, in order to remove contaminating microorganisms that might be acquired by subsequent occupants and/or staff. In some instances, discharge/transfer cleaning might be used when some types of Additional Precautions have been discontinued.
- Page 107- 10.2.1.2 Discharge/Transfer Patient/Resident Room Cleaning when a patient/resident is discharged, transferred or dies, the room or bed space must be cleaned and disinfected thoroughly before the next patient/resident occupies the space to

prevent the transfer of microorganisms to the new client/patient/resident. Cleaning and disinfection upon discharge includes several steps not required during routine daily cleaning (see 10.2.1.1 Daily Routine Cleaning of Patient/Resident Room or Bed Space) and requires the close cooperation of clinical staff and cleaners.

Review of the home's Infection Prevention and Control Manual, outbreak management and role of housekeeping, indicated:
- Specific terminal cleaning procedures may be indicated for certain organisms, in outbreak situations. In such cases, thorough cleaning and disinfection with a disinfectant known to be effective against the organism in question should be performed. Attention should be paid to frequently touched surfaces such as doorknobs, call bell pulls, faucet handles, and wall surfaces, which have been frequently touched by the resident. If the call bell pulls are not made of metal or plastic that can be easily disinfected, they should be discarded, and new ones installed.

Review of the floors' housekeeping staffing schedule for a seven-day period showed that: there were no housekeeping staff working in the home on three days, and only one staff working as janitor for four days.

Review of a list of the rooms that had terminal cleaning done by the Environmental Service Manager (ESM), showed several resident rooms had been terminally cleaned after residents' death, but the complainant’s / resident’s room was not among the list.

During interview with ESM, they stated that prior to the disease outbreak, the housekeeping staffing complement covered different shifts. Most of the staff were not working and sometimes they had only one staff in the building. To overcome the short staffing problem, with the help of Corporate office, agency staff were hired. The home tried to hire new housekeeping staff and full-time staff were requested to work extra hours; even other staff were doing the housekeeping job.

During interview with Senior Nursing Officer (SNO) from the Canadian Armed Forces (CAF), they indicated that half of their staff were assigned in general duty roles, helping in laundry and housekeeping, and half of their staff were assigned as personal support workers. During interview with ESM, they reported that CAF staff were not doing terminal cleaning in resident rooms.

During interview with ESM, they stated during the disease outbreak, there was no change in the cleaning and disinfecting policies, daily cleaning and high touch area

cleaning were in place. They stated terminal cleaning should be done after a resident expires and after the family collects the resident's belongings, by using a one-step disinfectant cleaner. Everything should be cleaned from bed to curtain rods and the entire environment. After the terminal cleaning, everyday cleaning and disinfecting with a one-step disinfectant cleaner should be continued. The ESM stated to ensure the rooms were clean, an audit would be done, but the audit was not done during the disease outbreak. They stated housekeepers weren't on the identified resident’s floor at the time, so rooms weren't cleaned, and janitors were only cleaning bathrooms and emptying the garbage. Terminal cleaning was a deeper cleaning to prevent spreading of infection and to remove the source of infection for other residents. ESM indicated although daily cleaning was done, terminal cleaning was not done.

During interview with ESM, they confirmed that housekeepers should stay on their respective floors, but janitors work on all floors. Janitors would help with terminal cleaning in terms of mopping the floor and helping to move the items. They stated many times they were not able to read and follow up with the Point Click Care (PCC) dashboard and room cleanings, due to added responsibilities during disease outbreak. They stated that during the disease outbreak there was no terminal cleaning in residents' rooms, except for the listed rooms which did not include the identified resident's room.

Review of the daily dashboard in PCC, showed daily announcement of residents' deaths which could be used by ESM as a guide for the rooms that required terminal cleaning.

During interview with the ED, they stated the home entered into a collaboration agreement with a Hospital, to work closely with an infection prevention and control SWAT team and an environmental team. Hospital, Toronto Public Health (TPH) and the home regularly held meetings together to establish processes and a plan of action. The home also implemented the MLTC directives and guidance for disease outbreak management. This collaboration continued until the outbreak was declared over, to support and implement systems and processes in phases for returning the home back to a "new normal".

During interview with hospital regional directors and manager of housekeeping, they reported that their team started before the disease outbreak was declared over, with terminal cleaning in the home. They stated full terminal cleaning was needed during the disease outbreak, and upon residents' discharge or death. The cleaning should be started when the discharged or deceased resident leaves the room, otherwise, the infection would be transferred when others touch items in the room, then go to the other

rooms. They stated if terminal cleaning was done during the disease outbreak, it would have reduced the risk of transmission of the infection.

Review of PCC dashboard showed that terminal cleaning started on the identified floor, and the identified resident's room was on the cleaning schedule.

Review of the residents' deceased list during the disease outbreak indicated residents' deaths and Toronto Public Health confirmed several residents' death related to the disease. More than half of residents were in a shared room with at least one other resident who had tested positive for the disease and their room had not received terminal cleaning.

During interview with ED, they stated that terminal cleaning should be done whenever the resident is discharged for any reason including death or discharge, and needed to be done as soon as the resident's belongings were removed from the room. The ED agreed it was quite a long time between residents' death in the identified resident's ward room and cleaning of the room. They stated during the disease outbreak, home was short of staff, the housekeeping staff were under pressure and were trying to focus on cleaning high touch surfaces. ED stated terminal cleaning was not done in resident rooms.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NAZILA AFGHANI (764), IVY LAM (646)
Inspection No. / No de l'inspection :	2020_754764_0008
Log No. / No de registre :	020014-19, 011677-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with O. Reg. 79/10, s. 87 (2).
Specifically, the licensee must:

1. Ensure that procedures are developed and implemented for cleaning the home, including resident rooms; floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

2. Conduct a bi-weekly audit to monitor the completion of terminal cleaning for all resident rooms, including after residents' death or discharge. The audit is to include but not be limited to the following information: unit name and room number, date of audit, person completing the audit, discharged resident's name, action taken and follow up.

3. The audit and documentation of follow up action(s) shall be made available for review for future follow up inspections. Thereafter, each of the areas in the home shall be audited on a routine basis established by the management team of the home.

Grounds / Motifs :

1. Findings/Faits saillants :
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residents' death in the identified resident's ward room and cleaning of the room. They stated during the disease outbreak, home was short of staff, the housekeeping staff were under pressure and were trying to focus on cleaning high touch surfaces. ED stated terminal cleaning was not done in resident rooms.
(764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 19, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nazila Afghani

Service Area Office /
Bureau régional de services : Toronto Service Area Office