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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 4, 2021	2021_631210_0019	007674-21	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

SLAVICA VUCKO (210), AMANDA NIXON (148), DIANNE BARSEVICH (581), MEAGAN MCGREGOR (721), SARAN DANIEL-DODD (116)

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): May 10-July 16, 2021 (on site and off site)

The following intake was completed in this complaint inspection:
Log #007674-21, related to nutrition and hydration and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Dietitian (RD), Physicians (MD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activities Assistants, Food Service Supervisor (FSS), Vice President from North York General Hospital and Infection Prevention and Control Lead (IPAC).

During the course of the inspection, the inspector observed resident and staff interactions and provisions of care, reviewed residents' clinical health records, home policies and procedures and the CAF statement and written responses.

The following Inspection Protocols were used during this inspection:
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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 :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #066 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

This inspection was initiated related to the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) team meeting minutes regarding concerns, alleging that residents were not fed and not offered fluids during the home's COVID-19 outbreak between January and June 2020.

During the inspection, the inspectors reviewed the health records of residents who expired during the identified time.

Resident #066 was admitted to the home on a specified date with multiple diagnoses. On an identified date, resident #066 was transferred to the hospital for further assessment and treatment due to a change in their health status. The discharge plan upon re-admission to the home, directed the home to return resident #066 to hospital if their health status worsened. Resident #066 passed away in the home on an identified date.

After the return from hospital, resident #066 was eating and drinking poorly, and their health status worsened.

There were no referrals or assessments completed when the resident presented with the reported conditions above.

As per the home's staff, the Physician should have been notified about the resident health status change for further assessment of the resident's condition and determine if further treatment was required.

The resident's condition was at risk of declining when the staff did not collaborate in their assessment of the resident related to their symptoms.

Sources: CIS report, resident #066’s clinical record including progress notes, hospital discharge report, related assessments and interviews with Physician #116, RD #113 and RPN #138 [s. 6. (4) (a)] [s. 6. (4) (a)]

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Issued on this 11th day of August, 2021

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

Original report signed by the inspector.