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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
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Original Public Report

Report Issue Date June 7, 2022
Inspection Number 2022_1100_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP; Linda Calabrese
3760 14th Avenue, Suite 402,
Markham, ON, L3R3T7

Long-Term Care Home and City
Hawthorne Place Care Centre
2045 Finch Avenue West,
North York, ON, M3N1M9

Lead Inspector
Joanne Zahur ID #589

Inspector Digital Signature
Joanne Zahur
2022.06.08 15:27:38 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 24, 25, 27, 31, and June 1, 2022.

Inspector #741076 was also present during this inspection.

The following intake(s) were inspected:

- Intake # 003956-22 (Complaint) related to Infection Prevention and Control program, Administration of Drugs, Falls Prevention, Resident Care, and Prevention of Abuse and Neglect,
- Intake #006950-22 (Complaint) and Intake #020433-21 (CIS #2586-000050-21) related to Prevention of Abuse.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary

Observations of the home's Infection Prevention and Control (IPAC) practices identified screener #101 did not follow the manufacturer's instructions for use of the rapid antigen test (RAT) on May 25, 2022. The instructions on the RAT kit indicated that the swab with the collected specimen was to stand in the extraction tube solution for two minutes prior to dispensing into the kit's testing device. The home failed to keep the swab standing in the extraction tube for two minutes as per manufacturer's direction

Interim Director of Care (I-DOC) #103 acknowledged that the manufacturer's instructions were not being followed to ensure accuracy of the test results.

There was actual risk of harm to residents, staff and visitors related to not following the RAT device's instructions as they pertain to the accuracy of the test results and consequently potential spread of infectious disease.

Sources: IPAC observation on May 25, 2022, review of BTNX Rapid Response device's instructions, interviews with screener #101, I-DOC #103, and other staff.

[#589]

WRITTEN NOTIFICATION PREVENTION OF ABUSE AND NEGLECT

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA 2007, s. 19 (1)

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The licensee has failed to ensure that resident #001 was protected from abuse by resident #002.

Rationale and Summary

The Ministry of Health and Long-Term Care (MLTC) received a critical incident report (CIR) and complaint related to an allegation of abuse towards resident #001 by resident #002.

Residents #001 and #002 were in an identified room. While there, resident #002 exposed themself to resident #001. Resident #001 became upset and when exiting the identified room, resident #002 touched them inappropriately.

Initially the incident was upsetting to resident #001, however there are no lasting ill-effects.

Sources: CIS report, record reviews, interview with resident #001, interviews with staff #'s 113, 114, 110, 111, and 112, and others.

[#589]