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
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date October 13, 2022
Inspection Number 2022_1100_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Hawthorne Place Care Centre, North York

Lead Inspector
Nital Sheth (500)

Additional Inspector(s)
Manish Patel (740841)

Inspector Digital Signature
Nital Sheth
Digitally signed by Nital Sheth
Date: 2022.10.19 11:47:28 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 8, 9, 12, 13, 2022

The following intake(s) were inspected:

- A complaint intake related to pest control, and Resident's transfer to another facility
- A complaint intake related to air conditioning in the residents' rooms
- CIS intake related to late reporting on Covid-19 outbreak

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

- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

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NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 23 (3)

The licensee has failed to ensure that the requirement related to measures to prevent the transmission of infections, listed under FLTCA, 2021, s. 23 (2) is complied with.

During an initial tour in the home, the inspector observed a family member coming out of the home area with Personal Protective Equipment (PPE). The family member disposed the PPE into the garbage bin in a common area. The inspector asked them about the PPE disposal process. The family member confirmed that they were supposed to remove and dispose the PPE inside the resident's room. The Director of Care (DOC) indicated that the Infection Prevention and Control (IPAC) lead educated the family member and the similar event did not occur after that.

Sources: Observations, Interviews with the DOC, IPAC lead and the family member.

Date Remedy Implemented: September 13, 2022 [500]

WRITTEN NOTIFICATION MANDORY REPORTING

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (1) (5)

The licensee has failed to ensure that the Director is immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the *Health Protection and Promotion Act*.

Rationale and Summary

The Public Health Unit (PHU) declared the home in an outbreak. The home initiated a report the following day to the Director**.** The Ministry of Long-term Care (MLTC) after hour pager was not contacted. As per the IPAC Lead, the CIS report for the outbreak should have been reported immediately to the Director.

Sources: CIS, interview with the IPAC Lead. [500]