Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: March 1, 2023	
Inspection Number: 2023-1100-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Rykka Care Centres LP	
Long Term Care Home and City: Hawthorne Place Care Centre, North York	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature** Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2023.03.06 08:32:04 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 26, 27, 31, February 2, 3, 6, and 7, 2023

The following intake(s) were inspected:

- Intake: #00018184 - [Critical Incident (CI): 2586-000004-23] – related to fall with injury
- Intake: #00012646 - [CI: 2586-000060-22], Intake: #00018358 - [CI: 2586-000005-23], Intake: #00020105 - [CI: 2586-000009-23] – related to a missing resident
- Intake: #00002081 - [CI: 2586-000034-21] – related to medication
- Intake: #00017896 – anonymous complaint related to multiple care concerns

The following intake(s) were completed:

- Intake: #00004167 - [CI: 2586-000036-21], Intake: #00001651 - [CI: 2586-000032-21], Intake: #00003164 - [CI: 2586-000035-21], Intake: #00003618 - [CI: 2586-000039-22], Intake: #00001054 - [CI: 2586-000044-22], Intake: #00004776 - [CI: 2586-000002-22], Intake: #00005833 - [CI: 2586-000047-22], Intake: #00006766 - [CI: 2586-000015-22], Intake: #00006780 - [CI: 2586-000048-22], Intake: #00016067 - [CI: 2586-000068-22] and Intake: #00007025 – all related to fall with injury

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Pain Management
Resident Care and Support Services
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.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the use of their adaptive equipment was no longer necessary and their care needs changed related to a fall prevention intervention to minimize injuries from a fall.

1. A resident's clinical records indicated that an adaptive equipment always be placed within the resident's reach to reduce falls risk.

During the inspection, a resident was observed in bed with their adaptive equipment located away from the resident. Staff stated that the intervention was no longer necessary since the resident no longer used their adaptive equipment.

On January 27, 2023, the Director of Care (DOC) stated the resident's clinical records were revised to reflect their current care needs.

SOURCES: Observations in the home, a resident's clinical records and staff interviews.

Date Remedy Implemented: January 27, 2023

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2. A resident's clinical records indicated resident to have an intervention in place at all times to safeguard against injury. At the time of inspection, a resident was observed without the intervention. Staff stated that they did not assist the resident with the intervention because they were in bed.

Another staff stated that the resident required the intervention but was not in place because of the changes in the resident's current health status. The staff and the DOC both stated that the resident was encouraged to use the intervention.

On January 27, 2023, DOC stated that resident's clinical records were revised to reflect resident's current care needs.

SOURCES: Observations in the home, a resident's clinical records and staff interviews.

Date Remedy Implemented: January 27, 2023

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's plan of care was provided as specified in the plan.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received an anonymous complaint regarding a resident's pain management and multiple care concerns. At the time of inspection, the resident was no longer in the home.

Review of a resident's clinical records indicated potential for acute pain and alteration in comfort related to their medical diagnoses. The resident was prescribed pain medication three times daily and

the staff to complete monthly Pain Evaluation Summary. Completed monthly Pain Evaluation Summary revealed that the Pain Evaluation Summary were missed twice. The home's policy indicated that Pain Evaluation Summary to be completed after three-day period of observation and monthly.

Staff stated that the resident was not able to verbalize their needs and would show facial grimacing when in pain. Review of Pain Evaluation Summary with the staff and the Assistant Director of Care (ADOC) confirmed that the Pain Evaluation Summary were missed twice.

Because the home failed to complete the monthly Pain Evaluation Summary of a resident, there was a potential that the treatment plan to effectively manage the resident's pain was not fully met.

SOURCES: A resident's clinical records, home's policy, "Pain Management," RCS G-60 revised date June 27, 2022 and staff interviews.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that when the plan of care for a resident was revised because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

Rationale and Summary

The home submitted three CI reports related to a missing resident. On all incidents the resident was located in the same area and returned to the home with no injury.

The home had a policy in place for Leave of Absence (LOA) and instructions on what to do in the event the resident did not return as expected.

The resident's clinical records were reviewed and revised after the first incident to include interventions related to the resident's high risk of elopement. The resident's clinical records were not revised to include a different approach to mitigate resident's high risks of elopement after the second incident.

The resident was capable and aware of the LOA privileges and processes. They stated that they forgot to call the home when they did not return as expected. The staff indicated the home had no way of contacting the resident once on LOA. Staff also stated that there was no new approach implemented after the second incident since the home exhausted all possible interventions and the resident was cognitive.

Because the home failed to consider different approach in resident's plan of care related to their elopement, the resident's health and safety remained at risk.

SOURCES: A resident's clinical records, home's policy, "Leave of Absence," RCS B-30 revised date May 31, 2022 and staff interviews.

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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with s. 174.1 (1) of Long-Term Care Homes Act (LTCHA), 2007 and s. 184 (3) of the Fixing Long Term Care Homes (FLTCA) Act 2021.

On April 11, 2022, the FLTCA 2021 and O. Reg 246/22 came into force, which repealed and replaced the LTCHA 2007 and O. Reg 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 174.1 (1) of LTCHA. Non-compliance with the applicable requirement also occurred after the April 11, 2022, which falls under s. 184 (3) of the FLTCA.

1.Non-compliance with: LTCHA 2007, s. 174.1 (1)
The licensee failed to comply with Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia effective April 15, 2020, requiring the licensee to ensure that review and analysis of all incidents of severe hypoglycemia or unresponsive hypoglycemia were completed.

Specifically, the home failed to document, review and analyze an incident of severe hypoglycemia with glucagon use involving a resident.

Rationale and Summary

The home submitted a CI when a resident suffered severe hypoglycemia. The home's policy indicated that any incidents of severe hypoglycemia and glucagon use will be treated as a medication incident and appropriate actions will be taken as per policy. The Interdisciplinary Team will meet quarterly and annually to evaluate every written record of the described incident to identify utilization trends and patterns and to identify any changes necessary to improve care and treatment of severe hypoglycemia, unresponsive hypoglycemia and when glucagon was used. Review of the home's Professional Advisory Committee (PAC) meeting minutes on a specified date did not include any documentation, review and analysis of the incident.

Interview with the home's consultant stated that medication incidents involving the use of the glucagon were reviewed and analyzed by the interdisciplinary team quarterly as well as annually and documentation captured in their PAC meeting.

Review of the home's records and PAC meeting minutes on a specified date did not indicate any documentation, review and analysis of the severe hypoglycemia incident that occurred involving a resident. Staff interviews indicated that the review and analysis of the Hypoglycemia involving a resident was missed.

Because the home failed to document, review and analyze severe hypoglycemia incident involving glucagon use for a resident, there was a potential that gaps in the processes that could minimize potential harm to the residents in the future were not identified.

SOURCES: CI #2586-000034-21, Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, effective April 15, 2020, homes policy "Reporting the Use of Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, F-45-10" created on February 25, 2020, home's PAC Meeting Minutes, home's Medication Incident Tracker Sheet, a resident's clinical records and staff interviews.

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2. Non-compliance with: FLTCA 2021, s. 184 (3)
The licensee failed to comply with Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, requiring licensee to ensure that confirmed outbreak management should include at a minimum increased cleaning and disinfection practices (eg. at least two times a day and when visibly dirty for high touch surfaces) in accordance with COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units Version 9- January 18, 2023.

Specifically, when staff did not clean and disinfect frequently touched surfaces in the suspected COVID-19 outbreak unit using at a minimum a low-level disinfectant, more than once per day.

Rationale and Summary

Public Health Ontario (PHO) COVID-19- Key Elements of Environmental Cleaning in Healthcare Settings, current as of July 16, 2021, indicated that high touch or frequently touched surfaces should be cleaned and disinfected once per day and more frequently in outbreak areas. At the time of inspection an identified home area was on suspected COVID-19 outbreak. Another home area was declared on confirmed COVID-19 outbreak four days after the suspected COVID-19 outbreak was resolved.

Staff stated that the cleaning and disinfection of high touch areas inside the residents' rooms were only done once a day even if the home area was on suspected COVID-19 outbreak. Environmental Services Manager (ESM) stated staff were expected to clean and disinfect high touch surfaces twice and more frequently if the home area was on outbreak.

Because the home did not ensure that enhanced environmental cleaning and disinfection of high touch surfaces were implemented, there was an increased risk of possible reservoir of infectious agents and spread of disease transmission

SOURCES: Observations on January 26, 2023, Minister's Directive COVID-19 Response Measures for Long-Term Care Homes, effective August 30, 2022, Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units Version 9 – January 18, 2023, PHO-COVID-19- Key Elements of Environmental Cleaning in Healthcare Settings, current as of July 16, 2021 and staff interviews.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard). Specifically, additional requirements 6.1 under IPAC standard required the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

Rationale and Summary

1. On a specified date, observations were made in different home areas. Three identified residents' rooms were on enhanced IPAC precautions. The identified rooms had no PPE available at point of care.

Review of the home's policy indicated that required PPE to be placed at the entrance of affected residents' room (donning station) and ensure PPE disposal system in place upon exit of the resident's room (doffing station).

Staff stated that the identified resident rooms were on enhanced IPAC precautions and confirmed that PPE were not available at point of care. IPAC Clinical Director of Care stated that all the required PPE were expected to be available at point of care.

Failure to provide PPE in accordance with the additional precautions at point of care increased the risk of infection transmission.

Sources: Observations in the home, IPAC Standard for Long Term Care Homes, April 2022, home's policy on "Droplet & Contact Precautions, F-05-20" last review date August 11, 2022, review of residents clinical records and staff interviews.

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2. An identified resident room was on enhanced IPAC precaution. IPAC signage posted outside of the identified resident's bedroom door indicated the required PPE prior to entry: gown, gloves, mask and eye protection. There was no PPE caddy containing PPE outside of the identified resident's room.

Review of the home's policy indicated that when providing direct resident care (providing Activity of Daily Living (ADLs)/Continuing Care Level (CCLs), feeding etc.), the following were required: gown, gloves, procedure or surgical mask, eye protection (goggles) or face protection (shield) and N95 respirator might be required based on Point of Care Risk Assessment.

A staff was observed providing meal tray service to residents in the identified room without eye protection. Review of resident's clinical records indicated that the resident was newly admitted to the home. Staff confirmed that the resident in the identified room was on enhanced IPAC precaution. Staff and IPAC Clinical Director both stated that residents who were newly admitted in the home was required to quarantine as per the home's process. IPAC Clinical Director also stated that staff were expected to wear all the required PPE when going inside a resident's room on enhanced IPAC precaution.

The staff acknowledged that they did not wear all the required PPE specifically the face shield or eye protection when they provided meal tray service in the identified resident's room because there was no face shield available at point of care.

Because the PPE were not available and accessible at point of care, there was an increased risk of infectious disease transmission.

SOURCES: Observations on January 26, 2023, IPAC Standard for Long Term Care Homes, April 2022, home's policy on "Droplet & Contact Precautions, F-05-20" last review date August 11, 2022, review of a resident's clinical records and staff interviews.

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