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**
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

# Original Public Report

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| **Report Issue Date:** April 3, 2023 | |
| **Inspection Number:** 2023-1100-0005 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** Rykka Care Centres LP | |
| **Long Term Care Home and City:** Hawthorne Place Care Centre, North York | |
| **Lead Inspector**<br>April Chan (704759) | **Inspector Digital Signature**<br>April W Chan Digitally signed by April W Chan Date: 2023.04.19 10:12:44 -04'00' |
| **Additional Inspector(s)**<br>Joy Ieraci (665) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 7-10, 13-17, 2023.

The following intakes were completed on this critical incident system inspection:
Intake #00001536 related to skin and wound care;
Intake #00002331 related to suspected resident to resident abuse;
Intake #00012372 related to skin and wound care;
Intake #00015054 related to infection prevention and control;
Intake #00020188 related to medication management.

Inspectors, Preethi Dayanand (000758) and Patricia McFadgen (000756) attended this inspection.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other in the assessment of the resident's behaviours so that their assessments are integrated and are consistent.

**Rationale and Summary**

The resident demonstrated responsive behaviours towards co-residents in a number of different occasions.

A Registered Practical Nurse (RPN) and the Behavioural Supports Ontario (BSO) lead identified that registered staff followed a referral process to BSO for residents who exhibit responsive behaviours. The BSO lead's role included reassessing a resident's responsive behaviours and providing recommendations in the management of responsive behaviours.

A referral to BSO was first made for the resident after a number of incidents in which they were demonstrating responsive behaviours towards a co-resident. The BSO lead indicated that they should have been informed of behavioural incidents involving the resident after the first incident, but that was not done.

There was risk identified when a referral to BSO was not sent for the resident when they first exhibited behaviours towards other residents.

**Sources:** the resident's medication administration records, progress notes and orders, interviews with an RPN and the BSO lead. [704759]

## WRITTEN NOTIFICATION: Reporting Certain Matters to Director

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report an incident of alleged and suspected abuse to a resident.

**Rationale and Summary**

A critical incident was received by the Ministry of Long-Term Care (MLTC) a day after an alleged incident occurred between a resident who engaged in non-consensual sexual touching to another resident.

An Assistant Director of Care (ADOC) acknowledged that the alleged abuse incident should have been reported immediately to the MLTC, and not the day after it had occured.

**Sources:** Critical incident report, interview with an ADOC. [704759]

## WRITTEN NOTIFICATION: Directives by Minister

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to the long-term care home, the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes was complied with.

In accordance with the Minister's Directive, the licensee was required to ensure they managed the care of symptomatic individuals, as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units was followed. Specifically, when a resident is symptomatic, they must self isolate and be placed on Additional precautions, medically assessed, and tested.

**Rationale and Summary**

A resident reported symptoms of infection on a specific date. Registered staff identified that for residents who were symptomatic, they would be tested for COVID-19 and kept isolated. An RPN stated that testing and isolation of the resident was not done on the date they had the onset of their symptoms.

On a later date, the resident reported symptoms of infection and was immediately placed on additional precautions and tested for COVID-19 by staff members.

There was risk identified when the resident was symptomatic and not placed on additional precautions and tested because they would not receive increased monitoring.

**Sources:** Critical Incident report, the resident's progress notes, interviews with a registered staff, and an Infection Prevention and Control (IPAC) lead. [704759]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee failed to ensure that a staff member participated in the implementation of the infection prevention control program related to active screening of a resident for symptoms of COVID-19.

**Rationale and Summary**

The home's policy entitled Active Screening of All Residents stated that active screening of all residents for COVID-19 symptoms will be undertaken in the home to identify the presence of infection. All residents were to be screened twice a day in the home.

Registered staff and an IPAC lead identified that twice a day active screening of residents for symptoms of COVID-19 was performed on an assessment tool. A review of assessments for a resident showed that a completed assessment tool was missing for a specific date and time. An RPN indicated the assessment tool was not done for that specified date and time.

There was risk identified when the active screening assessment tool of the resident was not done for the specified date and time.

**Sources:** the home's policy entitled Active Screening of All Residents, the resident's progress notes, assessments, registered staff and an IPAC lead. [704759]

## WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that every medication incident involving a resident was documented and must be complied with.

Specifically, staff did not comply with the policy "Medication Incident", which was included in the licensee's Medication Management System.

**Rationale and Summary**

The home's Medication Incident policy required that a Medication Incident Report be completed immediately in the home's electronic Medication Incident Report System (MIRS).

A medication incident occurred involving a resident on a specific date, and was discovered the following day. The Medication Incident Report was completed, after it was requested by the inspector.

The Director of Care (DOC) and an ADOC confirmed that the Medication Incident Report was not completed immediately as per the home's policy.

The home's medication management system may not be as effective when the medication incident was not documented immediately for analysis and review.

**Sources:** Review of the home's Medication Incident policy, the resident's Medication Incident Report and clinical records; and interviews with DOC and an ADOC. [665]

## COMPLIANCE ORDER CO #001 Duty to protect

**NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: Non-compliance with: FLTCA, 2021 s. 24 (1)**

The licensee shall:

1. Train all registered staff who work on specific resident home areas, including any agency registered staff, on initiation and monitoring of a specific medication administration method for residents.
2. Re-train all registered staff who work on specific resident home areas, including any agency registered staff, on the processing of physician orders.
3. Maintain a record of the training conducted, including the date, who provided the training and content of the training.

[665]

**Grounds**
**Non-compliance with: FLTCA, 2021 s. 24 (1)**

The licensee has failed to ensure that a resident was protected from neglect by three Registered Practical Nurses (RPNs) on a number of dates.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

**Rationale and Summary**

The home submitted a Critical Incident System (CIS) report, regarding an incident of improper/incompetent treatment of a resident which resulted in harm or risk to the resident.

The resident had an infection and refused to eat and drink on a specific date. The physician wrote an order at the start of the evening shift on the specified date, to improve on their health status.

RPN #102 received report from the day RPN that the resident was not eating and drinking and was aware of the physician's order for the resident. The RPN indicated they were not familiar with providing the treatment as specified on the physician's order and asked Agency RPN #111 for assistance.

Both RPNs reviewed the order together and found that the order was not complete and required clarification from the physician. RPN #102 informed RPN #111 they would follow up with the morning nurses as they were scheduled to work the following day shift.

Both RPNs did not call the physician to clarify the order and did not ask the Registered Nurse (RN) Supervisor to assist them in processing and initiating the physician's order for the resident.

RPN #102 documented that the resident was noted by the personal support worker (PSW) later that evening shift to have further deteriorated on their health status.

The home’s investigation notes indicated that the RN Supervisor did not receive a request to assist in processing and initiating the physician's order from RPNs #102 and #111.

RPN #102 stated they provided report to the night Agency RPN #109, that the order had not been processed and initiated for the resident.

RPN #109 indicated they did not process the physician's order.

In the morning of the next day, the Director of Care (DOC), discovered that the order had not been initiated. They found the physician's order was not processed by the registered staff.

The day RPN informed the DOC that they did not receive a report regarding the order.

The DOC stated the resident had a significant change in their health status upon their assessment. The Nurse Practitioner (NP) was notified. They confirmed the significant changes in the resident's health status and ordered the resident to be transferred to the hospital. The consult notes from the hospital indicated the resident had an improved health status after the similar order from the home's physician was rendered to the resident in the hospital.

The DOC verified that RPNs #102, #111 and #109 were responsible for initiating the physician' order for the resident, calling the physician to clarify the order and asking the RN Supervisor for assistance, which did not occur in the incident.

The resident's health and well being was impacted when the physician's order to improve on the resident's health status was not initiated and processed by RPNs #102, #111 and #109, which contributed to the resident's change in status and transfer to hospital.

**Sources:** the resident's clinical records, home's investigation notes and hospital consult notes; and interviews with RPNs #102 and #109 and DOC #100. [665]

**This order must be complied with by** May 12, 2023

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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