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

Report Issue Date: December 18, 2023
Inspection Number: 2023-1100-0008
Inspection Type: Complaint Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Hawthorne Place Care Centre, North York

Lead Inspector	**Inspector Digital Signature**
Dorothy Afriyie (000709)	

Additional Inspector(s)
Ramesh Purushothaman (741150)
Henry Chong (740836)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20, 22, 25-29, 2023, October 3, 4, 2023 and November 21-24, 2023

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00090285 - was related to improper care and neglect.
- Intake: #00090476 - was related to falls prevention and management;
- Intake: #00092631 - was related to sexual abuse;
- Intake: #00093058 and Intake: #00095919 - were related to neglect of resident.
- Intake: #00093919 - was related to infection control;
- Intake: #00094025 - was related to physical abuse

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The following intake(s) were completed in this complaint inspection:

- Intake: #00096355 – was related falls prevention, health status, diet, nail care and missing items.
- Intake # 00098294 – was related to improper care and neglect of a resident

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REQUIRED PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their Falls Prevention and Management policy related to post fall management.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury and be complied with.

Rationale and Summary:
The home submitted a CI report related to a fall with injury. On a specified date, a resident was left unattended in the dining room and sustained a fall. The resident sustained an injury resulting in a change in their ambulatory status.

Registered Practical Nurse (RPN) assessed the resident after the fall and the resident was not able to weight bear, so staff transferred the resident to the chair. However, the resident was not transferred to the hospital until nine days following the fall.

The home's Policy "Post Fall Assessment RCS E-155" revised May 2023, indicated that if a resident is unable to weight bear, or the registered staff assessing the resident does not believe the resident is safe to be transferred, do not move the resident:

- Notify the physician/NP immediately and provide them with the assessment, vital signs and the clinical symptoms or evidence of the injury.
- Call emergency services and prepare for transfer to the hospital for further assessment if needed.

Assistant Director of Care (ADOC) confirmed that the resident should have been

transferred to hospital immediately after the fall as specified in the policy.

Failure to transfer the resident immediately after the fall increased the risk of delayed treatment and further complications.

Sources: Resident #001's clinical record, Interviews with RPN #121, ADOC #120, and the home's Policy "Post Fall Assessment RCS E-155" revised May 2023.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
Integration of assessments, care
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,
 (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.

The licensee has failed to ensure that the staff and others involved in different aspects of care collaborated with each other in the implementation of floor mat to a resident's care plan so that the different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary:
A resident had a fall and sustained an injury. Physiotherapist (PT) stated that they

completed an assessment and recommended specific aide to be implemented as part of their falls management strategies.

On three different observations, there was no falls prevention aide observed in the resident's room. RPN confirmed that the falls prevention aide was not in the resident's care plan and was not implemented. Registered Nurse (RN) confirmed the same. Both RPN and RN stated that there was an increased risk of injury if falls prevention aide was not in place in the event of resident fall.

Failure to collaborate in developing and implementing the specific aide as part of the plan of care for falls prevention, posed a risk of injury in the event of a resident fall.

Sources: Observations, resident #006's clinical records, interviews with PT # 104, RPN #112, RN #116.

[741150]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
In accordance with FLTCA, 2021 s. 6 (9) 1, the licensee shall ensure that the provision of the care set out in the plan of care is documented.

Rationale and Summary:
A resident was transferred to the hospital on August 30, 2023, and was diagnosed with a specific medial condition.

Record review indicated that nutrition intake and snack intake were not documented on the day shift on multiple days. Personal Support Worker (PSW) confirmed there was missing documentation during the day shift on a multiple dates.

Director of Care (DOC) and Registered Dietitian (RD) confirmed that nutrition and snack intakes were documented inconsistently.

Failure to consistently document the nutrition and snack intakes placed the resident at an increased risk of delayed interventions to meet the resident's nutritional needs.

Sources: Resident #002's POC documentation for August 2023, interviews with DOC #127, RD #131, PSW #128; and resident #002's care plan.

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COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse

by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee shall:

1. Conduct an audit, at minimum of once daily for resident #004, to ensure that they are distanced from resident #003 as specified in resident #004's plan of care. Audits shall be conducted for a period of seven days following the service of the order.
2. Maintain a record of the above audit, including the date and time, who conducted the audit, residents audited, results of each audit, and actions taken in response to the audit findings.
3. Select three residents from the third floor and conduct an audit, at a minimum, three audits every seven days of their 24-hour fluid intake to determine if their daily fluid goals are being met. The audits shall be conducted for a minimum of three weeks following the service of this order.
4. Maintain a documented record of the above audit to include, but not limited to: resident audited, the resident's fluid intake, fluid goal, if they met their goals, any actions taken in response to the audits and staff compliance with the home's hydration policy.
5. Retrain and educate all third-floor registered staff, and Personal Support Workers on:
   - The meaning of neglect as defined by Ontario Regulation 246/22, s. 7,
   - Review the incident related to resident #002 in the context of neglect,
   - The home's hydration policy, including the process of referring to a Registered Dietitian when required by the policy.
6. Maintain a record of all the training provided, including the date, who conducted the training, and the contents of the training that was provided.

Grounds

The licensee has failed to ensure that a resident was protected from sexual abuse by another resident and a resident was not neglected by staff.

Rationale and Summary:

For the purpose of the Act and the Regulation:

- Sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("maivais traitements d'ordre sexuel");
- Neglect" means 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."

(i) A CI report was submitted by the home related to sexual abuse between two residents.

On a specified date, a PSW discovered resident #003 in resident #004's bedroom. Resident #004 brought resident #003's onto their bed and the resident was undressed and exposed their genitals to resident #003. Resident #003 was unable to provide consent.

RPN and ADOC confirmed that sexual abuse occurred between the two residents.

Sources: CI report 2586-000056-23; resident #003 and resident #004's clinical records; and interviews with PSW, ADOC, and other staff.

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(ii) The home submitted a CI report on a specified date, related to staff neglect of a

resident that resulted in harm. The resident was transferred to the hospital on a specified date, with several health related issues and subsequently passed away.

Record review showed a pattern of inaction by staff when the resident's health started to decline:

As per the home's hydration policy, a registered staff will initiate a Dietary referral for each resident who has not consumed their required amount of fluids for a 24-hour period over a three day span once it is determined there is no reason for reduced consumption.

The resident had a specified target daily fluid intake. No referral was sent to the Registered Dietitian (RD) when the resident's daily fluid intake was not met on three specified dates.

RD acknowledged that they did not receive a referral when the resident consumed less than their daily target intake over three consecutive days.

On a specified date, during an evening shift, a PSW advised that the resident was unable to drink from a cup and had a residual of food in their mouth. The resident was displaying certain health conditions. This change in resident health condition was reported by the PSW to a RPN.

On a specified date, a RPN tried to administer the resident's liquid medication in a cup, but they were unable to swallow so a syringe was used. RN indicated they did not receive any report of a change in resident's condition.

Documentation from a specified date, indicated that resident had less than 25 percent of lunch and their fluid intake was not documented. A RN was made aware of the resident's poor intake by a PSW but did not take action.

On specified date, during the night shift, a PSW informed a RPN that the resident was not behaving as usual and was speaking incoherently. RPN advised the PSW

that they had no concerns and documented that the resident slept through the night.

On a specified date, resident slept most of the shift and refused breakfast and lunch. A PSW reported this to a RPN. The RPN stated they checked the resident's blood pressure and administered scheduled medications.

On a specified date, a PSW observed the resident was lethargic, weak, and slept most of the shift. The resident was pocketing food during dinner and had difficulty swallowing. Documentation on the evening shift on a specified date, indicated that the resident refused their meal, and drank a small amount of fluid. RPN received a report related to meal refusal from PSW.

No assessments, intervening actions, nor notifications to a Nurse Practitioner or physician were carried out by registered staff when resident's condition deteriorated during the specified date.

The resident's family visited on a specified date, and reported to a RPN that the resident had a change in condition. There was no documentation of an assessment related to this concern, despite the resident's home area being in an outbreak.

On a specified date, at approximately midnight a PSW reported to a RPN that resident had a significant change in condition. The resident was transferred to the hospital.

Nurse Practitioner stated they were not notified of a change in resident's health condition. They stated they should have been notified when the resident was not eating or meeting their fluid target. Physician indicated the medical team should have been contacted when there was a change in resident's health condition and the resident was neglected when they did not receive treatment when needed.

DOC acknowledged that the resident was neglected due to lack of assessment or

intervention when there was a decline in the resident's condition. Also, the home's hydration policy was not followed when a referral was not sent to the RD. The expectation was for the registered staff to follow up with RD and the physician.

Failure to assess and intervene when there was a change in resident's health status, placed them at increased risk of compromised care and negative health consequences.

Sources: Resident #002's clinical records, Resident Hydration Policy RCS C-40, revised March 2023, interviews with DOC, RD #131, RN #129, PSWs #134, #136, #143, RPNs #138, #139, and physician #142.

[000709]

This order must be complied with by

January 24, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an

order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #001 issued on April 3, 2023, in inspection #2023-1100-0005

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

The Licensee shall :

1. Re-educate PSW #118, #105, and RPN #132 on the process of reviewing residents' plans of care and ensuring that falls prevention interventions are in place.
2. Conduct audits weekly for four weeks for resident #001 and #008 to ensure that their fall prevention interventions are implemented as specified in their plan of care,
3. Maintain a record of the training provided, including the date, who conducted the training, and contents of the training that was provided,
4. Maintain a record of the audits conducted, including staff who were audited, the auditor, results of the audit, and any actions taken to address the audit findings.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided in relation to residents #001 and #008's falls prevention interventions and resident #005's shower schedule, as specified in their plan.

Rationale and Summary:

(i) Resident #008's plan of care indicated that staff were to ensure that they wore appropriate footwear (fitted shoes or non-skid socks) for ambulation.

On a specified date, the resident was observed wearing oversized and inappropriate footwear. Interviews with a PSW and a RPN confirmed that the resident was wearing

inappropriate footwear, which was not considered fitted shoes. A PSW confirmed that there was a risk of the resident falling if they were not wearing appropriate footwear.

Failure of staff to ensure that the resident was wearing appropriate footwear increased their risk of falling and injury.

Sources: Observations, Resident #008's care plan, interviews with PSW #124 and RPN #125

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(ii) On specified date, a resident reported to the home that a PSW did not provide them their scheduled shower on the proper day.

The resident's plan of care indicated that they were scheduled showers on a specified day. A PSW confirmed they didn't provide the resident their scheduled shower on a specified day and date.

Failure to provide resident #005 with a shower as scheduled increased their risk for skin impairment and caused the resident distress.

Sources: Resident #005's clinical records; and interviews with PSW #118, and other staff.

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(iii) A resident's plan of care indicated that the resident wore a specified falls preventative aide on all shifts and to have their call the bell within reach when in bed. The Resident was observed not having their call bell within reach and not wearing falls preventative aide on three specified dates.

RPN #121, #132, and PSW #105 acknowledged that resident's care plan was not followed. ADOC acknowledged that the resident was at an increased risk for injury when they weren't wearing their falls preventative aide and their call bell wasn't within reach.

Failure to apply falls preventative aide and ensure the call bell was within the resident's reach has placed them at an increased risk for injury and compromised their ability to call for assistance, especially in case of an emergency.

Sources:: Resident #001's record review, observations on September 22, 25, and 28, 2023; and interviews with RPN #123, #132, PSW #105, and ADOC #120.

[000709]

This order must be complied with by January 24, 2024

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.