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: February 29, 2024

Inspection Number: 2024-1100-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Rykka Care Centres LP

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

Lead Inspector	**Inspector Digital Signature**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.03.01 13:31:16 -05'00'

Additional Inspector(s)
Reji Sivamangalam (739633)
Trudy Rojas-Silva (000759)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29, 30, 31, 2024 and February 1, 2, 5, 6, 7, 8, 2024.

The following intake(s) were inspected:

- Intake: #00106268 [Critical Incident System (CIS) #2586-000005-24)] related to disease outbreak.
- Intake: #00103383 (CIS #2586-000106-23) related to alleged abuse of a resident.
- Intake: #00103685 (CIS #2586-000107-23) related to alleged neglect of a resident.
- Intake: #00103981 was a complaint.

- Intake: #00104663 - Follow-up inspection #01 to Compliance Order (CO) #002: FLTCA, 2021 - s. 6 (7); related to Plan of Care.
- Intake: #00104664 - Follow-up inspection #01 to CO #001: FLTCA, 2021 - s. 24 (1); related to Duty to Protect.
- Intake: #00107451 (CIS #2586-000009-24) related to fall prevention and management.

The following intake (s) were completed:

- Intake: #00098311 (CIS #2586-000080-23) and Intake: #00098708 (CIS #2586-000083-23) were related to fall prevention and management.
- Intake: #00099998 (CIS #2586-000087-23) Intake: #00100867 (CIS #2586-000094-23) and Intake: #00107629 (CIS #2586-000011-24) were related to disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2023-1100-0008 related to FLTCA, 2021, s. 6 (7) inspected by Noreen Frederick (704758)

Order #001 from Inspection #2023-1100-0008 related to FLTCA, 2021, s. 24 (1) inspected by Noreen Frederick (704758)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 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.

Licensee has failed to ensure the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:

A resident left the dining room unassisted and had a fall which resulted in an injury.

Review of the resident's clinical records indicated that they needed one staff extensive assistance with ambulation at the time of their fall.

A Personal Support Worker (PSW) was assigned to the resident's care on the day of the fall and confirmed they were aware that the resident needed one staff extensive assistance for ambulation, however they did not assist the resident when they left the dining room.

A Registered Practical Nurse (RPN) confirmed it was unsafe for the resident to walk unassisted out of the dinning room.

Nurse Clinician (NC) stated that if a resident got up to walk they should be provided the necessary support that followed their plan of care.

Staff failed to provide the resident with the necessary assistance during ambulation which placed the resident at risk for injury as a result of a fall.

Sources: Interviews with RPN, PSWs #124, #126, NC , and the resident clinical records.

[000759]

WRITTEN NOTIFICATION: Prevention of abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was not neglected in identifying a skin impairment and providing the required treatment.

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:

A resident had a history of developing a specific skin impairment.

The resident had a skin assessment completed by an RPN, which found multiple skin breakdowns. The image captured as part of the assessment included evidence

of the existence of an additional skin impairment. RPN acknowledged that they did not fully assess the area, including the second skin impairment. A review of clinical records indicated that no treatments or interventions were provided for the second skin impairment. No follow-up assessments were completed during this period.

The resident's skin impairment worsened. A review of documentation and interviews with RPN #133 and RPN #134 verified that the wound deterioration was not reported to the registered staff. Physician stated that they were not informed about the open skin areas. PSW #136, 137 and 138 acknowledged that staff were required to check the resident's skin and notify the registered staff of any skin impairments.

Skin and Wound care Lead and the DOC stated that the staff were expected to check the resident's skin during care and report any skin impairment to the registered staff. They acknowledged that the staff members failed to conduct proper skin examinations during the care and report the presence of skin impairments to the registered staff on multiple shifts for several days. They also verified that the registered staff were expected to assess skin impairments regularly, and acknowledged that the registered staff did not assess the resident's skin impairments .

Failure to properly assess the resident's skin led to delay in identifying and treating a skin impairment effectively.

Sources: Resident's progress notes, assessments, and treatment records, CIS #2586-000107-23, Home's Skin Risk Assessment and Head-to-Toe Skin assessment policy (Index I.D #RCS- G-35-05, revised on May 23, 2023), interviews with PSW #136, 137 and 138, RPN #132, 133, 134 and135, Skin and Wound Care Program Lead, Physician and the DOC.

[739633]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Specifically, staff did not comply with policy #RCS P-10 "Abuse and Neglect", dated February 3, 2023, which stated the first step of an investigation is to ensure the resident(s) health and, police are to be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident(s) that may constitute a criminal offence.

Rationale and Summary:

(i) As per a resident, a PSW grabbed them by the arm and caused them pain to which they tried to pull their arm away but could not and this made them feel weak. The resident stated that they sustained an injury from the PSW grabbing them.

Review of the resident's clinical records did not indicate that the resident was assessed for injuries immediately after they made the allegation.

The home's policy on Abuse and Neglect indicated that when the resident reported the allegation of staff to resident physical abuse, the first step is to immediately ensure that the resident's health. Review of the resident's clinical records did not indicate that the resident health was immediately assessed for injuries.

Assistant Director of Nursing (ADON) confirmed the home's policy was not complied

with as the resident's health should have been assessed for injuries the same day they brought forward the allegation.

Failure of the home to comply with their own policy in relation to an allegation of staff to resident abuse placed the resident at risk of delayed interventions.

Sources: Interview with ADON and the resident, resident's clinical records, policy on Abuse and Neglect #RCS P-10, updated Feb. 3, 2023.

Rationale and Summary:

(ii) As per a resident, a PSW grabbed them by the arm and caused them pain to which they tried to pull their arm away but could not, and this made them feel weak. The Resident stated they sustained an injury from the PSW grabbing them.

Review of the resident's clinical records, the home's investigation notes, and the critical incident (CI) report did not indicate that police were notified or that there was a police investigation.

The home's policy on Abuse and Neglect stated handling a resident in a rough manner and the unauthorized use of physical force is a form of abuse and may constitute a criminal offence. Therefore police should have been notified immediately once the incident was reported.

Special Project Nurse (SPN) confirmed they were aware of the home's process for handling allegations of staff to resident physical abuse and was delegated to report the incident to the Director, but failed to comply with the policy as they did not notify police.

ADON stated the incident did constitute a criminal offence and police should have been called but were not, which did not comply with the home's abuse and neglect

policy to immediately notify police of any alleged incident of abuse of a resident that may constitute a criminal offence.

Failure of the home to comply with their own policy in relation to an allegation of staff to resident abuse placed the resident at risk for delayed interventions.

Sources: Interview with SPN , ADON and the resident, resident clinical records, policy on Abuse and Neglect #RCS P-10, updated Feb. 3, 2023.

[000759]

WRITTEN NOTIFICATION: Binding on licensees

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirement set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed. The document required that masks be worn indoors in all resident home areas.

Rationale and Summary:

(i) On January 29, 2024, a Housekeeper was observed in a resident's room as well as in the hallway with their surgical mask below the nose. They acknowledged that they did not wear the surgical mask properly and there was a risk for infection transmission to them and the residents. IPAC Lead stated that masks were to be worn properly inside the home.

Due to the home not ensuring that the masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: inspector's observation, interviews with the housekeeper and IPAC Lead, and COVID-19 guidance document for long-term care homes in Ontario last updated November 7, 2023.

Rationale and Summary:

(ii) On January 29, 2024, a Lab technician was observed in a resident's room with their surgical mask below the chin. They acknowledged that they were to keep their mask on at all times. IPAC Lead stated that masks were to be worn properly inside the home.

Due to the home not ensuring that the masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: inspector's observation, interviews with the Lab Tech and IPAC Lead , and COVID-19 guidance document for long-term care homes in Ontario last updated November 7, 2023.

Rationale and Summary:

(iii) On February 01, 2024, a housekeeper was observed in the dining room with three residents surrounding them with their surgical mask below their chin. They acknowledged that they did not wear the surgical mask properly and there was a risk for infection transmission to them and the residents. IPAC Lead stated that masks were to be worn properly inside the home.

Due to the home not ensuring that the masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: inspector's observation, interviews with the housekeeper and IPAC Lead , and COVID-19 guidance document for long-term care homes in Ontario last updated November 7, 2023.

[704758]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1(b & d) states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) and Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary:

(i) On January 29, 2024, a PSW was observed twice entering and exiting a resident's room with additional precautions. Each time they did not perform hand hygiene with each before or after resident/resident environment contact, did not change their N95 mask, and did not sanitize their face shield. They acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact, change their N95 mask after the resident contact and sanitize their face shield.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with PSW and IPAC Lead and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(ii) On January 29, 2024, a RPN was observed entering and exiting a resident's room with additional precautions. Each time they did not perform hand hygiene before or after resident/resident environment contact, did not change their N95 mask, and

did not sanitize their face shield. They acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact, change their N95 mask after the resident contact and sanitize their face shield.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with RPN and IPAC Lead , and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

[704758]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary:

(i) On January 29, 2024, a housekeeper was observed entering and exiting a resident's room several times while touching the dirty rags, broom, garbage, wall and curtains. Each time they entered or exited the room, they did not perform hand hygiene before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with Housekeeper and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(ii) On January 29, 2024, an RPN was observed entering and exiting two resident rooms to administer the medication. Each time they entered or exited those rooms, they did not perform hand hygiene before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident

environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with RPN and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(iii) On January 29, 2024, an Activity Aide was observed touching two residents, transferring two residents with assistive devices, and moving several objects in the dining room. They did not perform hand hygiene with each before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with Activity Aide and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(iv) On January 29, 2024, a PSW was observed entering and exiting three resident rooms and assisted them to the dining room. They did not perform hand hygiene with each before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform

hand hygiene before and after resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with PSW and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(v) On January 29, 2024, a Lab technician was observed entering and exiting four resident rooms with gloves on, the changed their gloves, however they did not perform hand hygiene with each before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the lab technician was required to perform hand hygiene before and after resident/resident environment contact.

Due to the lab technician's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with Lab technician and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary:

(vi) On February 1, 2024, an RPN was observed entering and exiting a resident's room with gloves on. They did not perform hand hygiene with each before or after resident/resident environment contact and acknowledged inspector's observations.

IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with RPN and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Specifically, IPAC Standard for Long-Term Care Homes, s. 10.4 (h & i) states that the licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; and Support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Rationale and Summary:

(vii) Observations on January 29, 2024 of the IPAC practices related to residents' hand hygiene identified that staff did not support residents in performing hand hygiene prior to lunch. IPAC Lead stated that the staff was required to assist residents in performing hand hygiene before lunch.

Due to staff failing to assist the residents with hand hygiene, there was a risk of harm to residents related to spread of infectious disease.

Sources: Inspector's observations, interviews with IPAC Lead and other staff, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023). [704758]