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: May 8, 2024

Inspection Number: 2024-1100-0002

Inspection Type:
Critical Incident

Licensee: Rykka Care Centres LP

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

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.05.14 10:11:04 -04'00'

Additional Inspector(s)
Nrupal Patel (000755)
Michael Chan (000708)
Trudy Rojas-Silva (000759)
Carrie Normand (000859) was present during this inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 8-12, 15-17, 2024
The inspection occurred offsite on the following date(s): April 5, 2024

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

- Intake: #00105780 [CI: 2586-000001-24] - related to allegations of physical abuse and skin and wound care
- Intakes: #00108045 [CI: 2586-000014-24], #00108543 [CI: 2586-000019-24], and #00111284 [CI: 2586-000029-24] - related to physical abuse of a resident by another resident, and skin and wound care

- Intake: #00108174 [CI: 2586-000015-24] - related to neglect of a resident and pain management
- Intake: #00108419 [CI: 2586-000016-24] - related to a disease outbreak
- Intake: #00108471 [CI: 2586-000017-24] - related to improper/incompetent care of a resident
- Intake: #00109379 [CI: 2586-000022-24] - related to a potential sexual abuse of a resident
- Intake: #00111380 [CI: 2586-000030-24] - related to a fall of a resident resulting in injury
- Intake: #00112590 [CI: 2586-000036-24] - related to an incident that caused injury for which resident was taken to hospital

The following intake was completed in this CI inspection:

- Intake: #00109604 [CI: 2586-000026-24] - related to a fall of a resident resulting in injury

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as, "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
A Personal Support Worker (PSW) witnessed two residents engaged in a physical altercation. The resident struck the other resident, which resulted in an injury. Staff intervened and the incident ended. The PSW, Behavioural Support Lead (BSO Lead), and Director of Care (DOC) confirmed that the resident used physical force and caused injury to the other resident.

Failure to protect a resident from physical abuse by the another resident led to the resident sustaining injuries.

Sources: Both residents' clinical records, CI #2586-000029-24, interviews with a PSW and other staff.

[000708]

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.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the physical altercation between two residents was immediately reported to the Director.

Rational and Summary
A PSW witnessed a physical altercation between two residents. The home submitted a CI to the Director the next day after the incident.

DOC acknowledged the incident should have been reported to the Director immediately.

Failure to immediately reported the incident to the Director did not place the resident at risk.

Source: CI #2586-000029-24; and interviews with DOC and other staff.

[000708]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure a resident was assessed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial intervention.

Rationale and Summary
A resident reported to the Social Worker that their pain needs were not addressed by a nurse during their shift.

It was identified that the resident complained of pain to the Registered Practical Nurse (RPN) after their routine analgesic medication were administered to them.

Review of the resident's clinical records indicated the RPN did not complete a pain assessment when the resident complained of pain to them, nor did they provide them with pain relief when initial interventions were ineffective.

The RPN acknowledged they did not complete a pain assessment or provided the resident with pain relief, when the resident complained of pain to them.

The Home's Policy stated if a resident is in obvious pain they were to be given analgesics and a pain assessment must have been completed.

An Assistant Director of Care (ADOC) stated the home's expectation was for the RPN to follow the pain management policy which they did not, as they did not complete a pain assessment when the resident expressed they were in pain.

Failure to complete a pain assessment once initial interventions were not effective, placed the resident at risk of ineffective pain management.

Sources: Interview with an RPN and an ADOC, home investigation notes, home's pain management policy, resident clinical records.

[000759]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken to respond to the needs of residents demonstrating responsive behaviours, including interventions were documented for a resident.

Rationale and Summary
A resident demonstrated responsive behaviours of physical aggression towards

another resident, and staff had initiated a behavioural monitoring tool as a result of this incident.

A review of the resident's behavioural monitoring tool revealed that staff were required to document the resident's observed behaviours at a scheduled interval for a week. However, there was no documentation for two particular dates and three different shifts.

DOC confirmed that staff were expected to monitor the resident and document based on the scheduled timing indicated on the behavioural monitoring tool for all shifts.

Failure to document the resident's responses to interventions on the behavioural monitoring tool could have led to staff's inability to accurately assess and analyze resident's behaviours during the observation period and implement further interventions if required.

Sources: A resident's clinical records; Interviews with BSO Lead and DOC.

[000710]

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 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team,

including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

Rationale and Summary
A PSW was observed providing beverages and snacks to two residents. The PSW did not assist with hand hygiene or offer hand hygiene to both residents prior to eating and drinking.

Another resident was observed requesting snacks from another PSW. The PSW was then observed providing snacks to the resident. The PSW did not assist with hand hygiene or offer hand hygiene to the resident prior to eating.

Both PSWs confirmed they did not encourage or assist the residents in performing hand hygiene prior to serving the snack.

The IPAC Lead and DOC both acknowledged that staff must assist residents with hand hygiene before snacks.

Failure to assist the resident with hand hygiene before snacks put them at risk for infection transmission.

Sources: Observations; interviews with PSWs, IPAC Lead and the DOC.

[000755]

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

1) Upon the service of this order, conduct audits weekly for three weeks for all shifts (days, evenings, and night) of a specified resident home area's supply of specific objects to ensure they are kept secured, locked and are only accessible by the home's staff and authorized personnel of the home.

2) Conduct training for all direct care staff, registered nursing staff, and one-to-one staff for a resident on a specified resident home area regarding a resident's plan of care related to safety check and removal of specific objects, and the home's policies and procedures on how to conduct the safety check.

3) Maintain a record of the training including the trainer, staff who were trained, time and date(s) of the training, and topics covered in the training.

4) Conduct audits on the provision of care to a resident, for tasks and interventions related to staff safety checks and removal of specific objects set out in their plan of care. Audits should be performed at minimum twice a week for all shifts (days,

evening, and nights) for three weeks.

5) Maintain a record of audits conducted for the provision of care of a resident and supply of specific objects, including staff who were audited, the auditor, time and dates of the audit, results of the audit, and actions taken in response to the audit finding.

Grounds
The licensee has failed to ensure that the home was a safe and secure environment for a resident when the resident used an object to inflict self-harm.

Rationale and Summary
A resident was found with significant injuries. A resident used an object to inflict self-harm. Staff provided medical interventions and transferred the resident to the hospital.

A Registered Nurse (RN) stated that the resident was found with two objects at the time of the incident with one of the objects noted to be the same as the home's supply and the other was different. BSO Lead indicated that the resident obtained the object outside the home. A PSW indicated that one of the objects used was from the home's supply. The home was unable to determine how the resident was able to acquire these objects.

The resident's plan of care indicated that staff are to complete safety checks and to report to registered staff or management if any high-risk objects were found.

During an observation, the home's supply of specific objects were stored in an unlocked storage area. An RN stated that PSWs could access the objects from the storage area as needed for residents. DOC confirmed these objects supplied by the

home should have been kept locked and secured, and only be accessible by authorized staff.

The BSO Lead, a PSW, an RN, and DOC indicated that the resident should not have had access to any of the objects. The BSO Lead and an RN confirmed that the home was not a safe and secure environment for the resident when these objects were able to be accessed by residents.

Failure to ensure that the home was a safe and secure environment for the resident jeopardized the safety and wellbeing of the resident.

Sources: CI #2586-000036-24; the resident's clinical records; observations; and interviews with BSO Lead, an RN, DOC and other staff.

[000708]

This order must be complied with by June 7, 2024

COMPLIANCE ORDER CO #002 Plan of care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

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

1) Provide education to a PSW on the home's policies and procedures related to the completion of the behavioural monitoring tool.

2) Provide education to all direct care staff and registered nursing staff on a specified resident home area on the home's falls prevention and management policies and procedures including obtaining fall interventions equipment, supplies, devices and assistive aids.

3) Maintain a record of the training including the trainer, staff who were trained, time and date(s) of the training, and topics covered in the training.

4) Conduct audits weekly for four weeks on the behavioural monitoring tool and documentation by a PSW for one resident per week or until four audits have been completed.

5) Conduct audits weekly for four weeks for a resident to ensure that their fall interventions are implemented on all shifts as per the plan of care.

6) Maintain a record of audits conducted, including staff and resident who were audited, the auditor, time and dates of the audit, results of the audit, and actions taken in response to the audit findings.

Grounds
The licensee has failed to ensure that the care set out in two residents' plan of care was provided as specified, specifically related to their fall interventions, and behavioural monitoring tool.

Rationale and Summary

i) A resident was observed not wearing a fall intervention equipment. The resident's care plan at the time of the observation indicated that they were at risk for falls and required to wear the fall intervention equipment at all times to safeguard against injury.

A PSW confirmed that the resident's fall intervention equipment was soiled and did not have any replacements available. An ADOC indicated that staff were expected to report to the ADOC, Ward Clerk and/or Charge Nurse when a resident did not have any fall intervention equipment available in order to obtain a replacement immediately.

Failure to ensure that a fall intervention equipment was applied as set out in their plan of care could lead to an increased risk for injury in case of a fall.

Sources: A resident's clinical records; Observations of the resident; and Interviews with a PSW and an ADOC

[000710]

ii) A resident had a fall that resulted in injury and the resident was subsequently provided with medical interventions.

The care plan at the time of the fall indicated that the resident was to utilize a fall intervention equipment during ambulation. The home's investigation revealed that the resident had a different fall intervention equipment applied at the time of the incident.

A PSW confirmed that they could not locate the resident's fall intervention

equipment and therefore had applied a different fall intervention equipment prior to the fall incident. DOC indicated that the staff were expected to apply the specific fall intertervention equipment as specified in the resident's plan of care.

Failure to ensure that the resident utilized the specific fall intervention equipment as set out in their plan of care increased the resident's risk for falls.

Sources: The resident's clinical records; Home's investigation notes; and Interviews with a PSW and DOC.

[000710]

iii) A behavioural monitoring tool was initiated for a resident due to changes in their health conditions, and for safety related to their history. The resident was on a behavioural monitoring tool at a scheduled interval for a specific number of days to observe their health conditions.

A PSW found the resident at a specific time and date with significant injuries. The resident was found with injuries in multiple areas after being self-inflicted by the resident by utilizing an object. Staff provided medical interventions and transferred the resident to the hospital.

The PSW documented a check prior to its scheduled time in Point Click Care (PCC). The PSW indicated they interacted with the resident prior to the incident but did not visually observe the resident.

DOC and BSO Lead indicated that PSWs were responsible for completing the behavioural monitoring tool. DOC indicated the staff are expected to visually observe a resident when completing the behavioural monitoring tool and document

the observations at point of care.

DOC, BSO Lead, an RN, and the PSW stated that there was risk to the safety of the resident when the behavioural monitoring tool was not completed as directed.

Failure to ensure the resident was visually observed as specified in their plan of care placed the resident at risk of not receiving timely interventions when they were engaged in behaviours of self-harm.

Sources: CI #2586-000036-24, interview with the home's management and staff, the resident's clinical record.

[000708]

This order must be complied with by June 14, 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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Written Notification issued on February 29, 2024, under inspection report #2024-1100-0001
Compliance Order issued on December 18, 2023, under inspection report #2023-1100-0008
Written Notification issued on March 1, 2023, under inspection report #2023-1100-0004
Written Notification and Voluntary Plan of Correction issued on October 6, 2021, under inspection report #2021_766500_0024

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.

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

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.