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

Public Report

Report Issue Date: December 23, 2024

Inspection Number: 2024-1100-0005

Inspection Type:
Critical Incident
Follow up

Licensee: Kindera Living Care Centres LP by its general partners, Kindera Living Care Centres GP Inc. and Kindera Living Management Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 13, 16-18, 2024

The following intake(s) were inspected:

- Intake: #00126301: follow-up on a previously issued Compliance Order (CO) related to duty to protect
- Intake: #00126411/Critical Incident (CI) #2586-000087-24 and intake: #00127048/CI #2586-000088-24 - related to prevention of abuse and neglect
- Intake: #00129864/CI #2586-000095-24 - related to a disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1100-0004 related to FLTCA, 2021, s. 24 (1)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with respect and dignity. A personal support worker (PSW) was being rude and yelled at the resident during the care provided to them. The resident expressed feeling embarrassed at the time of the incident.

Sources: Home's investigation notes, interview with residents and staff.

WRITTEN NOTIFICATION: Prevention of abuse

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 protected from sexual abuse by another resident.

Section 2 (1) of the Ontario Regulation 246/22 defines sexual abuse as "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.

A PSW had witnessed a resident kissing another resident and touching them inappropriately. The resident had cognitive impairment and they were unable to consent.

Sources: CI report #2586-000088-24, homes investigation notes, clinical records and interviews with staff.

WRITTEN NOTIFICATION: Failed to comply with abuse and neglect policy

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.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

On a specified date, a registered practical nurse (RPN) did not comply with the licensee's "Prevention of Abuse and Neglect Policy" (INDEX I.D: RCS P-10), last reviewed on June 27, 2024. As outlined in the investigation section of the policy, designated staff members were required to ensure the health and safety of residents through a head-to-toe assessment. Two residents did not receive the required assessments until a day after a suspected abuse incident occurred.

Sources: Residents' health records, CI report #2586-000088-24, home's investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Mandatory reporting

NC #004 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 a suspected resident to resident abuse

incident was immediately reported to the Director. A CI report regarding suspected resident to resident abuse was submitted to the Director one day after the incident had occurred.

Sources: CI#2586-000088-24 Report, home's investigation records and interviews with staff.