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: April 16, 2025

Inspection Number: 2025-1100-0001

Inspection Type:
Critical Incident

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): April 8-11, 14-16, 2025

The following intake(s) were inspected:
· Intake: #00140355 - [Critical Incident System (CIS): 2586-000007-25] - Enteric outbreak

The following intake(s) were completed:
· Intake: #00144612 - [2586-000013-25] - Covid-19 Outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Visitor policy

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (1) (a)
Visitor policy
s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum,
(a) includes the process for visitor access during non-outbreak situations and during an outbreak of a communicable disease, an outbreak of a disease of public health significance, an epidemic, a pandemic or another emergency;

The licensee has failed to ensure that the visitor policy was implemented.

Public Health recommended the Long Term Care Home (LTCH) to implement active screening due to confirmed outbreak. LTCH's visitor policy stated that visitors and caregivers to the home must undergo proper screening and the screener's job routine stated that visitors will not be allowed into the home if they failed the screening by answering yes to any of the screening questions related to the outbreak. On an identified date, two visitors were allowed entry to the home who failed the screening questions, and the IPAC Lead and/or the supervisor was not immediately informed as per the LTCH's policy.

Sources: Inspector's observations, LTCH's visitor policy # E-150, screener job routine, and interviews with the Personal Support Worker (PSW) and the Infection Prevention and Control (IPAC) Lead.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Develop and implement an auditing process to ensure that residents who are provided with tray service are offered and/or supported with performing hand hygiene prior to receiving meals in their room.

2. Conduct and document the audits in section one at minimum weekly, including breakfast, lunch, and dinner each week, for a period of four weeks on the second floor. The documentation must include, but not limited to, the date and time, the resident room number, the person completing the audit, and any corrective action taken as a result of the audit.

3. Develop and implement an auditing process to ensure that second floor staff are performing hand hygiene according to the four Moments for Hand Hygiene framework.

4. Conduct and document the audits in section three at minimum weekly, including the day, evening, and night shift each week, for a period of four weeks on the second floor. The documentation must include, but not limited to, the date and time, name of staff being audited, the person completing the audit, and any corrective action taken as a result of the audit.

5. Provide re-education and training to second floor staff on the home's hand hygiene program.

6. Maintain a record of the training provided in section five, including the date and time, who conducted the training, and name of staff who attended the training.

7. Develop and implement an auditing process to ensure that second floor staff including the home's Nurse Practitioner (NP) are following the appropriate sequence for donning and doffing personal protective equipment (PPE).

8. Conduct and document the audits at minimum weekly, including the day, evening, and night shift each week, for a period of four weeks on the second floor. The documentation must include, but not limited to, the date and time, resident's room number, type of precautions, the person completing the audit, and any corrective action taken as a result of the audit.

9. Provide re-education and training to second floor staff including the home's NP on the proper sequence for donning and doffing PPE.

10. Maintain a record of the training provided in section nine, including the date and time, who conducted the training, and name of staff who attended the training.

Grounds

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) states that the licensee shall ensure that Routine Practices and Additional Precautions were 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).

(i) An observation revealed that a Registered Practical Nurse (RPN) did not perform hand hygiene before and after taking a resident's blood pressure; and two PSWs did not perform hand hygiene before and after resident/resident environment contact.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), Long-Term Home's (LTCH) hand hygiene and glove use policy #IPAC H-15, and interviews with the RPN, and PSWs.

(ii) An observation revealed that a PSW did not perform hand hygiene after changing a resident's incontinent brief; and an x-ray technician did not perform hand hygiene before and after resident/resident environment contact.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), LTCH's hand hygiene and glove use policy #IPAC H-15, and interviews with the PSW and IPAC Lead.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1(f) states that the licensee shall ensure that at minimum, Additional Precautions shall include: additional PPE requirements including appropriate selection application, removal and disposal.

(i) An observation revealed that the NP did not doff their mask and face shield after being in contact with a COVID-19 positive resident.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), LTCH's PPE policy #IPC F-15, and interview with the NP.

(ii) An observation revealed that an RPN and a Recreation Aide doffed PPE improperly after being in contact with a COVID-19 positive resident. The RPN removed their gown first then gloves, did not perform hand hygiene, and removed face shield. Additionally, they did not change their surgical mask. The Recreation Aide removed the gown first then the face shield, continued to remove their gloves and did not perform hand hygiene, and removed their mask to don on a new mask without performing hand hygiene.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), LTCH's PPE policy #IPC F-15, and interviews with the RPN and the Recreation Aide.

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.

An observation revealed that two PSWs did not offer or assist three residents in completing hand hygiene prior to eating their lunch.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), LTCH's hand hygiene and glove use policy #IPAC H-15, and interviews with the PSWs.

This order must be complied with by June 6, 2025

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.