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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: June 29, 2023

Inspection Number: 2023-1100-0006

Inspection Type:
Follow up
Critical Incident System

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: 2023.06.29 16:04:41 -04'00'

Additional Inspector(s)
Rajwinder Sehgal (741673)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 31, 2023 and June 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 2023

The following intake(s) were inspected:
- Intake: #00021282 - [Critical Incident (CI): 2586-000024-23] – was related to alleged physical abuse
- Intake: #00085028 - Follow-up related to Duty to Protect
- Intake: #00086736 - [CI: 2586-000036-23] – was related to missing resident
- Intake: #00087631 - [CI: 2586-000037-23]- was related to responsive behaviours

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1100-0005 related to FLTCA, 2021, s. 24 (1) inspected by Noreen Frederick (704758)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when their responsive behaviour intervention was ineffective.

Rationale and Summary
A resident had a known history of exhibiting responsive behaviours towards co-residents. The resident's written plan of care related to responsive behaviour instructed staff to implement a specific intervention.

During inspector's observations, the intervention was not in place.

Registered Practical Nurse (RPN) stated that the intervention was ineffective and should have been removed from the care plan. Director of Care (DOC) acknowledged that the care plan was not updated as intervention was not effective.

The intervention was removed from the resident 's care plan on June 14, 2023.

Sources: Resident's written plan of care, progress notes, and interviews with RPN and DOC.

[741673]
Date Remedy Implemented: June 14, 2023

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)

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to abuse of a resident by staff that resulted in harm or a risk of harm to the resident.

A resident's family member alleged that the resident was hit by someone to a Registered Nurse (RN) and they observed an injury to the resident. The RN and the Assistant Director of Care (ADOC) stated that they had reasonable grounds to suspect improper or incompetent treatment or care of the resident. ADOC acknowledged that the incident should have been immediately reported to the Director and was not reported until two days later.

Failing to immediately report the incident of suspected improper or incompetent treatment may place residents at risk for potential continuation of such treatment.

Sources: CIS #2586-000024-23, resident's progress noes, and interviews with RN, and ADOC.

[704758]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and summary
The RN observed an injury to a resident. They stated that they did not complete a skin and wound

assessment related to these areas of altered skin integrity. Long-Term Care Home's (LTCH) skin impairment assessment in PCC policy #RCS G-35 stated "A Wound is an alteration in skin integrity, a breakdown in the protective function of the skin and/or where the blood supply to the dermal tissue is disrupted. Wounds include but are not limited to: Pressure/Venous/Arterial, Surgical, Bruises, Abrasions, Skin Tears, Rash, Diabetic, and Cancer Lesion".

ADOC acknowledged that that the skin and wound assessment should have been completed following the altered skin integrity being identified.

Failure to assess the resident's altered skin integrity placed them at risk for further deterioration of their skin integrity.

Sources: Resident's clinical records, LTCH's skin impairment assessment in PCC policy #RCS G-35 (last revised June 9, 2023), and interviews with RN, and ADOC.

[704758]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that when a resident exhibited responsive behaviours towards other residents, interventions were implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours.

Rationale and Summary
A CIS report submitted to the Director indicated that on an identified date, resident #003 displayed responsive behaviours towards resident #004.

Resident #003 had five incidents of responsive behaviours towards co-residents over the five months prior to this incident.

An external specialized service provider recommended that resident #003 have a behavioral intervention in place indefinitely at all times due to their responsive behaviours which put themselves and others at risk of harm. The intervention was implemented for resident #003 after the incident with resident #004.

The DOC acknowledged that based on the resident's history of responsive behaviours towards co-residents, the behavioural intervention should have been implemented earlier to prevent further incidents.

Failure to implement the intervention for resident #003 put residents and staff at risk of harm from resident #003.

Sources: Resident #003's written plan of care, progress notes, risk management, and interview with DOC.

[741673]