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

# Amended Public Report Cover Sheet (A1)

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|---|
| **Amended Report Issue Date:** September 24, 2024 |
| **Original Report Issue Date:** September 9, 2024 |
| **Inspection Number:** 2024-1100-0004 (A1) |
| **Inspection Type:**<br>Critical Incident<br>Follow up |
| **Licensee:** Rykka Care Centres LP |
| **Long Term Care Home and City:** Hawthorne Place Care Centre, North York |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
Inspection Summary for Intake: #00116960 [Critical Incident (CI): #2586-000052-24] was updated
NC #002 Amending an error in the resident numbering
NC #003 Amending an error in resident numbering and extending the Compliance Order due date of CO#001

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| **Inspection Type:**<br>Critical Incident<br>Follow up | |
| **Licensee:** Rykka Care Centres LP | |
| **Long Term Care Home and City:** Hawthorne Place Care Centre, North York | |
| **Lead Inspector**<br>Yannis Wong | **Additional Inspector(s)**<br>Cindy Ma<br>Henry Chong<br>Slavica Vucko |
| **Amended By**<br>Yannis Wong | **Inspector who Amended Digital Signature** |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
Inspection Summary for Intake: #00116960 [Critical Incident (CI): #2586-000052-24] was updated
NC #002 Amending an error in the resident numbering
NC #003 Amending an error in resident numbering and extending the Compliance Order due date of CO#001

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16, 19-23, 26-27, 29, 2024

The following Follow Up intakes were inspected:
• Intake: #00115762 - Follow-up CO #001 - 2024-1100-0002; FLTCA, 2021 - s. 5, CDD June 7, 2024
• Intake: #00115763 - Follow-up CO #002 - 2024-1100-0002; FLTCA, 2021 - s. 6 (7), CDD June 14, 2024
• Intake: #00119982 - Follow-up CO #001 - 2024-1100-0003; FLTCA, 2021 - s. 24 (1), CDD Aug 2, 2024

The following Critical Incident (CI) intakes were inspected:
• Intake: #00116960 [Critical Incident (CI): #2586-000052-24] - related to medication incident and improper care
• Intake: #00117550 - [CI: #2586-000054-24] - related to allegation of staff to resident emotional abuse
• Intake: #00119030 - [CI: #2586-000059-24] and Intake: #00119254 - [CI: #2586-000062-24] - related to resident to resident physical abuse
• Intake: #00119035 - [CI: #2586-000060-24] - related to fall with injury
• Intake: #00123813 - [CI: #2586-000078-24] - related to unexpected death of a resident

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1100-0002 related to FLTCA, 2021, s. 5 inspected by Cindy Ma

Order #002 from Inspection #2024-1100-0002 related to FLTCA, 2021, s. 6 (7) inspected by Yannis Wong

Order #001 from Inspection #2024-1100-0003 related to FLTCA, 2021, s. 24 (1) inspected by Cindy Ma

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# AMENDED 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 a resident was treated with respect and dignity by a Personal Support Worker (PSW).

**Rationale and Summary**
A Registered Nurse (RN) witnessed a verbal altercation in the hallway between a resident and PSW when they left the resident's bedroom. The RN separated the resident and PSW, then assessed and provided emotional support to the resident as they were visibly upset. During an interview with the resident, they stated that during the verbal altercation with PSW, they were rude, had gestured their hand back and forth in close proximity to their face, and the resident felt unsafe as a result of the incident.

The home's investigation indicated the PSW had told resident they were rude to all PSWs, asked the resident to leave their room, and spoke inappropriately to the resident. The Director of Care (DOC) confirmed the PSW was rude to the resident during the interaction.

Failure to ensure the PSW treated a resident with respect and dignity resulted in negative emotional impact to the resident.

**Sources**: Resident's clinical records; home's investigation notes; interviews with resident, RN, and DOC.

## WRITTEN NOTIFICATION: Police notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 105**

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of any witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

**Rationale and Summary**

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care regarding a witnessed incident of physical abuse on a specified date, between two residents that resulted in injury. There was no record that the police services were contacted.

The DOC confirmed the police were not called related to the incident and should have been contacted.

Failing to immediately notify the police of alleged incidents of abuse placed residents at risk of harm.

**Sources**: CI #2586-000059-24; resident's clinical records; interview with DOC.

## COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
1. Conduct audits daily for a period of two weeks to ensure that residents #004 and #005 are monitored and redirected by staff when in close proximity.
2. Conduct audits daily for a period of two weeks to ensure that all responsive behaviour interventions identified in resident #004's care plan are followed.
3. Maintain a documented record of the audits conducted in the above conditions to include, but not limited to: dates of audit completion, the staff member who conducted the audit, residents audited, results of each audit, and corrective actions taken in response to the audit.

**Grounds**
The licensee has failed to ensure that resident #005 was protected from physical abuse by resident #004, and resident #007 was protected from physical abuse by resident #008.

Section 2 (1) 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**
i) On a specified date, residents #004 and #005 had a physical altercation. A PSW

witnessed resident #004 being aggressive toward resident #005 and stated the residents were difficult to separate. Resident #005 sustained injuries, as a result of the physical altercation.

A Registered Practical Nurse and DOC confirmed resident #004 physically abused resident #005 when they used physical force and caused injury.

Failure to protect resident #005 from physical abuse by resident #004 resulted in injury to resident #005.

**Sources**: Resident #004 and resident #005 clinical records; home's investigation notes; interviews with PSW, RPN, and DOC.

ii) On a specified date, resident #007 became aggressive towards staff and other residents. Staff members, including a Social Service Coordinator (SSC) intervened and encouraged other residents to redirect from the area.

Resident #008 refused to be redirected to another area. Resident #007 was subsequently physically aggressive towards the SSC, who acted as a barrier between the two residents. At this time, resident #008 claimed that resident #007 touched them, and reached at resident #007 in response. Resident #007 sustained an injury and was subsequently transferred to the hospital related to aggression.

Review of both residents' clinical records indicated that resident #008 caused physical injury to resident #007. The SSC stated resident #008 injured resident #007. The DOC confirmed that physical abuse occurred between the residents.

Failure to protect resident #007 from physical abuse by resident #008 resulted in injury to resident #007.

**Sources**: Resident #007 and resident #008's clinical records; and interviews with SSC and DOC.

**This order must be complied with by** October 21, 2024

**This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.**

**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 #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $16500.00, 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:**
Compliance Order and Administrative Monetary Penalty issued for $11,000 on June 28, 2024, under Inspection #2024_1100_0003;
Written Notification issued on May 8, 2024, under Inspection #2024_1100_0002;
Written Notification issued on February 8, 2024 under Inspection #2024_1100_0001;
Compliance Order and Administrative Monetary Penalty issued for $5,500 on December 18, 2023, under Inspection #2023_1100_0008; and
Compliance Order issued on April 3, 2023 under Inspection #2023_1100_0005

This is the third 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

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.