Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2019	2019_766500_0020	014490-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

Long-Term Care Home/Foyer de soins de longue durée

Eatonville Care Centre
420 The East Mall ETOBICOKE ON M9B 3Z9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 6, 8, 9, 12, 13, 14, 15, 19, 2019.

The intake log #014490-19 related to duty to protect was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistants Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Coroner Investigation Officer, and Family Member.

During the course of the inspection, the inspector reviewed resident's clinical records, and home records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 49, the licensee was required to ensure that falls prevention and management program included, at a minimum, strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy regarding "Head Injury routine (HIR), (RCS E-35)", last revised July 2018, which is part of the licensee's falls prevention program. As per the policy, staff are required to initiate homes "Head Injury Routine" as per designated protocols using the "Neurological Flow Sheet" and as an outcome the home will have a record of initial and ongoing assessment of vital signs and level of consciousness. As per the policy, vital signs to be checked and recorded for seventy-two (72) hours on the Neurological Flow Sheet as follows:
Q (15) min x (1) hour
Q (30) mins x 2 hours
Q (1) hour x (5) hours
Q (4) hours x (16) hours
Q (8) hours x (48) hours (6 shifts)

The inspector expanded samples resident #006 and #007 as a result of non-compliance identified for resident #001 under the home's falls prevention program.

A review of resident #006's progress notes indicated that resident had an un-witnessed fall with no injury on an identified day. The resident was assessed and a head injury routine (HIR) was initiated.

A review of the resident's neurological flow sheet indicated that the HIR was not documented on two occasions during various shifts on two different days. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of resident #007's progress notes indicated that resident had a fall with no injury on an identified day. The resident was assessed and HIR was initiated.

A review of the resident's neurological flow sheet indicated that the HIR was not documented on three occasions during various shifts on three different days. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 52, the licensee was required to ensure that pain management program included, communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

Specifically, staff did not comply with the licensee's policy regarding "Pain Management, (RCS G-60)", revision date of July 15, 2013, was the policy that was in place at the time of the incident.

As per the policy, the assessment and evaluation include verbal communication with the resident to determine level and intensity of pain, and also observations of non-verbal cues such as; facial expressions (grimacing) guarding of a specific area, moaning, pain on movement, increased level of agitation, or any other behavior(s) outside the normal for the resident.

A review of the resident's clinical record indicated that the resident had mild cognitive impairment.

A review of the resident's progress note indicated that as per the hospital the resident passed away of specified health conditions. A review of the resident's progress noted

indicated that 12 days prior to the resident's death, the resident reported mild pain in an identified body area. The RPN administered pain medication.

A review of the resident's clinical record and progress notes did not indicate further assessment of the identified body area by the staff.

Interview with RPN #107 indicated that during a time when the resident reported pain, they had higher workload and therefore, did not complete further assessment of identified body area, however acknowledged that further assessment of the body area was required.

Interview with RN #102 indicated that they are required to complete further assessment of the body area. RN #102 also indicated that the resident is required to monitor and consult with Nurse Practitioner or doctor if required.

Interview with the DOC confirmed that the staff can not intervene without completing proper assessment. There is an RN available to assist the RPN if they need help to manage their workload.

This non-compliance is issued as a result of staff failed to comply with their pain management policy in order to identify a cause of the resident's pain. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of resident #001 is retained by the licensee for at least 10 years after the resident is discharged from the home.

Ministry of Long-term Care (MOLTC) received a complaint on an identified day, indicating concerns regarding resident #001's death.

Review of the resident's progress notes indicated on an identified day, the resident had an unwitnessed fall. The resident was not injured. An assessment was conducted and HIR was initiated.

A review of the resident's clinical records indicated that there was no HIR documentation available.

Interview with Registered Nurse (RN) #102, and Registered Practical Nurse (RPN) #104 indicated that for witnessed head injury during fall and for unwitnessed fall, the staff are required to initiate HIR and document it in a paper form which is placed in the resident's chart.

Interview with the Director of Care (DOC) indicated that they were not able to locate the resident's HIR information completed after the above mentioned resident's fall.

This non-compliance is issued as a result of the home failed to retain the resident's HIR documentation record as a result of the resident's fall event. [s. 233. (1)]

Issued on this 23rd day of August, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.