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
torontodistrict.mltc@ontario.ca

Amended Public Report (A3)

Report Issue Date: November 18, 2022

Inspection Number: 2022-1073-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Eatonville Care Centre, Etobicoke

Inspector who Amended	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.02.09 14:37:17 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the correct issue date of the licensee report.

The correct issue date for the Licensee Report is November 18, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): Oct 28, 31; Nov 1 -3, 7-8, 2022.

The following intake(s) were inspected:

- Intake: #00001381 [Critical Incident (CI): 2468-000015-22] related to fall with injury.
- Intake: #00002846 [CI: 2468-000016-22] related to injury of unknown cause.
- Intake: #00003726 related to injury of unknown cause.
- Intake: #00006462 related to fall with injury.
- Intake: #00007713 related to improper skin/ wound care.

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

- Falls Prevention and Management
- Infection Prevention and Control
- Pain Management

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 (1) (c)

The licensee has failed to ensure that there was a written plan of care for resident #002, that sets out clear directions to staff and others who provided direct care to the resident related to Activities of Daily Living (ADL).

Rationale and Summary

Resident #002's plan of care directed the staff to take precautions related to their diagnosis, during care.

Staff confirmed that the resident did not have a particular intervention and the care plan had not been revised to provide clear direction to staff. The care plan was subsequently updated to reflect the current care needs.

Sources: Resident #002's plan of care, Inspector observations and interviews with staff
Date remedied: Nov 07, 2022
[#741150]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Rationale and Summary
Observations on the floors revealed three bottles of expired hand sanitizer product. The IPAC lead removed the expired products from the units on the same day.

Observation revealed that there were two expired refills of hand sanitizers near the servery area on one of the floors. Five expired hand sanitizers refills were found inside the automatic dispensers in residents' rooms, and dining rooms on another floor. Staff acknowledged that there was an expired hand sanitizer refill in the housekeeping storage.

The expired refills were removed from the floors and confirmed by the Administrator.

Sources: Observations by inspector, Review of "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), Interview with IPAC lead, DOC and Administrator.

Date Remedy Implemented: Nov 7, 2022.
[741150]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

(i) On an identified date, resident #002 sustained a fall resulting in injury and was transferred to the hospital two days later. Falls intervention as specified in the care plan was not implemented at the time of the fall. After the fall, new interventions were implemented.

Staff stated that the one of the falls interventions was not in place at the time of the resident's fall. This was confirmed by the CIS as well.

During observations, a specific intervention mentioned in the care plan was not implemented. Observation on another day also found another intervention specified in the care plan was not implemented. Staff confirmed that the resident required the interventions for falls prevention and management.

Staff not implementing the interventions as per the plan of care, puts the resident at risk for falls related injuries.

Sources: Observations, resident #002's clinical record, Critical Incident System (CIS) report and Interview with staff.
[741150]

The licensee has failed to ensure that the care set out in the plan of care for toileting assistance was provided to the resident as specified in the plan.

Rationale and Summary

(ii) Resident #003 was diagnosed with an injury of unknown cause requiring hospital treatment. The resident's written care plan indicated that they required a certain type of transfer for an activity of daily living (ADL), and incontinent product to be changed at a certain frequency.

Documentation of the flow sheets for the above-mentioned ADL indicated that the required level of care was not provided by staff on three days.

Not proving care as per resident #003's plan of care for care led to improper support of the body during care and increased risk of body injuries.

Sources: Critical Incident System (CIS) report, resident #003's clinical record, and interviews with staff.
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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 *s. 102 (2) (b)*

The licensee had failed to ensure that staff performed hand hygiene before and after resident and resident environment contact.

Rationale and Summary

Staff was observed assisting a resident with an assistive device. They did not perform hand hygiene before donning gloves and cleaning the assistive device. Then they brought that assistive device to the resident's room. Before placing the assistive device in the resident's room, they assisted another

resident in the hallway, and then touched the clean assistive device again to put it back in the resident's room.

Another staff was observed to be touching a resident on their shoulder and left the room without performing hand hygiene. They then assisted another resident in the dining room and moved a snack cart without performing hand hygiene.

The home's policy titled "Hand Hygiene" directed staff to perform hand hygiene as per the four moments of hand hygiene: before initial contact with the resident and equipment in the resident environment, and after contact with the resident and equipment in the resident environment.

The Infection Prevention and Control (IPAC) Lead acknowledged that staff were to perform hand hygiene before and after coming into contact with a resident or resident's environment, and in between assisting residents.

Failure to ensure staff are performing hand hygiene as required by routine practices increased the risk of transmission of infection.

Sources: Observations, review of the LTCH's Infection prevention and control manual Hand Hygiene and Gloves, last revised August 2022, and interview with the IPAC Lead.
[741150]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when resident #003's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

Resident #003 sustained a fracture of unknown cause requiring hospital treatment. Resident's pain was not assessed for a period of 10 days.

The resident required a certain type of assistance for transfers and care. While providing care staff noted that the resident was in pain and the body part was not normal. The resident was hospitalized, and the hospital report confirmed that the resident had an old injury.

On an identified date, staff noted that the resident presented with signs of discomfort when care was provided. Staff assessed the resident for any injuries. They notified the Physician requesting to assess the resident during the next visit. Analgesic was administered with good effect. It was not documented if an assessment was conducted before and after administration, and during care. The Physician assessed the resident and prescribed another medication for pain.

The home's policy Pain Management, RCS-G60, indicated methods for pain assessments when a resident receives care, being moved, or when showing signs of discomfort. Staff to administer analgesics and complete Pain Assessment in point click care (PCC), monitor pain level on every shift for three consecutive days. On the fourth day staff to evaluate the pain treatment for efficacy.

Multiple staff reported to the nurse that resident #003 was expressing pain when care was provided. One of the analgesic medications was given, but the other was not administered to the resident during the same period to manage their pain. The Pain Assessment documentation was not completed for any new pain and pain during and after care. The assessment form guided staff to document when the pain got worse or better, the location, if it was continuous or intermittent, the timing, and conditions that may be indicative of pain.

There was no evaluation if the medication was effective for managing resident #003's pain.

Not evaluating resident #003's pain for treatment efficacy and not using the pain assessment form as per the home's policy, led to inadequate treatment and delayed identification of pain triggers.

Sources: Critical Incident System (CIS) report, home's policy Pain Management dated June 2022, resident #003's clinical record, and interviews with staff.
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