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

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Public Report

Report Issue Date: January 31, 2023

Inspection Number: 2023-1073-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Rykka Care Centres LP

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

Lead Inspector	**Inspector Digital Signature**
Adelfa Robles (723)	Adelfa P Robles — Digitally signed by Adelfa P Robles Date: 2023.02.05 22:53:12 -05'00'

Additional Inspector(s)
Wing-Yee Sun (708239)
Dorothy Afriyie (000709) was also present during this inspection.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 5-6, 9-10, 12-13 and 16-17, 2023

The following intake(s) were inspected:

- Intake: #00003400 - [Critical Incident (CI) 2468-000017-21] – related to neglect
- Intake: #00010848 - [CI 2468-000030-22] – related to neglect
- Intake: #00012752 - [CI 2468-000032-22] – related to physical abuse
- Intake: #00013428 - [CI 2468-000033-22] – related to injury of unknown cause
- Intake: #00010893 - [CI 2468-000020-22] – related to fall with injury
- Intake: #00008979 - [CI 2468-000029-22] – related to fall with injury
- Intake: #00010841 – related to fall with injury

The following intake(s) were completed:

- Intake: #00002664 - [CI 2468-000004-22], Intake: #00003094 - [CI 2468-000018-21], Intake: #00003230 - [CI 2468-000013-21], Intake: #00003234 - [CI 2468-000015-21], Intake: #00004750 - [CI 2468-000028-21], Intake: #00005026 - [CI 2468-000030-21], Intake: #00013850 - [CI 2468-000036-22] – were all related to falls with injury.

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT'S BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that a resident's rights to privacy when provided treatment was fully respected and promoted.

Rationale and Summary

A staff was observed providing a specific treatment to a resident in a common area. Other residents were present at the time.

The resident was unable to verbalize their consent to have the specific treatment completed in the common area.

The home's policy titled "Treatments, Diagnostic Procedure and Medications Not Administered at Meal Time" directed staff that treatments, diagnostics, procedures and medications were not to be administered during meal service in the dining room.

The staff acknowledged that the specific treatment for the resident was done in the common area and should have been done in a private location.

The Director of Care (DOC) acknowledged that the specific treatment was not to be done in the common area unless it was specified in the resident's plan of care.

Sources: Observations in the home, a resident's clinical records, the home's policy titled "Treatments, Diagnostic Procedure and Medications Not Administered at Meal Time – FNSMS100" reviewed June 28, 2022 and staff interviews.

[708239]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 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 provision of care for a resident was provided as specified in the plan.

Rationale and Summary

A) The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) regarding improper/incompetent treatment of a resident that resulted in harm or risk to the resident. The CI report indicated that a resident sustained an injury from unknown cause.

A resident's written plan of care indicated that they require two-person extensive assistance for all types of transfers. Home's investigation notes revealed that the staff assigned to the resident on an identified date transferred the resident alone.

Staff interviews indicated that staff were expected to follow the resident's plan of care. The Assistant Director of Care (ADOC) acknowledged that staff assigned to the resident did not follow the resident's plan of care as specified in the plan.

Sources: CI #2468-000033-22, a resident's clinical records, home's investigation records and staff interviews.

[723]

Rationale and Summary

B) On a specified date, a staff was observed transferring a resident alone. The resident's clinical records indicated that they require two-person extensive assistance for all types of transfers.

Staff confirmed that the resident required two-person extensive assistance for all transfers. The identified staff acknowledged that they did not follow the resident's plan of care when they transferred the resident alone.

There was an increased risk of injury to a resident when their plan of care was not followed as specified.

Sources: Observations in the home area, a resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulations 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

On a specified date, a resident used physical force towards another resident which resulted in an injury.

Staff acknowledged that they were the first to respond and witnessed the incident when the resident physically abused another resident.

The ADOC, Behavioural Support Ontario (BSO) Lead and other staff all acknowledged that the resident was physically abused by another resident.

Sources: CI #2468-000032-22, residents' clinical records, home's investigation notes and staff interviews.

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when residents fell a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary

A) The home submitted a CI report on a specified date when a resident was transferred to the hospital from an unwitnessed fall resulting in an injury.

The home's Post Fall Management Policy indicated that all residents were to be assessed post fall to determine extent, type of injuries and to assess contributing factors that may had caused the fall using a tool specifically designed for the purpose. The assessment would include but not limited to: level of consciousness, evidence of gross bleeding, damage to hip joint, vital signs, cognition, determine if witnessed and obtain account of the incident, observation for facial expression, tension, palpation on tenderness on major joints and Range of Motion (ROM).

The home documented the incident related to the resident's fall. Assessments were also documented related to the fall incident. The resident's clinical records on a specified date did not include all the required post fall assessments as per the home's policy.

Staff indicated that they were expected to complete and document a post fall assessment in the residents' clinical records and monitor the resident post fall using Data Action Response (DAR) format when documenting their assessments.

The Inspector reviewed the resident's clinical records with the staff. The staff acknowledged that the required and relevant components of the post fall assessments were not captured as required by the home's policy.

The home's Falls Lead stated that when a resident had a fall, staff were expected to complete and document their assessments related to the incident and to send referrals to Physiotherapist (PT) and Registered Dietitian (RD) as required.

The ADOC stated that staff were expected to complete and document all required and relevant assessments post fall as per the home's policy.

Sources: Home's Post Fall Management Policy last reviewed date August 2022, a resident's clinical records and staff interviews.

[723]

B) The home submitted a CI report when a resident was transferred to the hospital from an unwitnessed fall. The resident returned to the home with a new diagnosis.

A resident's clinical records indicated that the home documented assessments related to the resident's fall incident. A referral was sent to the home's PT and RD. There was no documentation of the post fall incident in the resident's clinical records.

Staff stated that they were expected to document their completed assessments in the residents' clinical records when monitoring a resident post fall. Staff stated that there was no specific post fall assessment tool for falls.

The ADOC stated that registered staff were expected to use a specific documentation note in the residents' electronic records when documenting their post fall assessments. The ADOC acknowledged that the post fall assessment for the resident was not documented in the specified electronic records and all the required post fall assessments were not captured as required by the home's policy.

When the home did not utilize a clinically appropriate post fall assessment instrument specifically designed for falls, required and relevant assessments were missed for the residents.

Sources: Home's Post Fall Management Policy review date August 2022, Achieva Health Policy & Procedure Manual Physiotherapist Post Fall Assessment, a resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 50 (2) (b) (i) of O. Reg. 79/10, under the Long-Term Care Homes Act (LTCHA), 2007 and s. 55 (2) (b) (i) of O. Reg. 246/22, under the Fixing Long Term Care Homes (FLTCA) Act 2021

On April 11, 2022, the FLTCA 2021 and O. Reg 246/22 came into force, which repealed and replaced the LTCHA 2007 and O. Reg 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (i) of O. Reg 79/10. Non-compliance with the applicable requirement also occurred after the April 11, 2022, which falls under s. 55 (2) (b) (i) of O. Reg 246/22 under the FLTCA.

1. Non-compliance with: O. Reg 79/10, under the LTCHA 2007, s. 50 (2) (b) (i)
The licensee has failed to comply with the process to assess a resident's altered skin integrity.

In accordance with O. Reg 79/10 s. 8 (1) b, the licensee is required to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and must be complied with.

Specifically, staff did not comply with the home's policy **"**Skin and Wound Assessment, G-35-10" revised June 2, 2021, which is part of the licensee's Skin and Wound Care Program.

Rationale and Summary

The home's policy **"**Skin and Wound Assessment" directed staff to assess the skin impairment immediately using the Point Click Care (PCC) Skin and Wound Application, and a picture should be taken during the initial Wound Assessment.

The home received a written complaint from a family and was forwarded to the MLTC when the resident developed skin impairment. Staff was informed about the resident's new skin impairment and acknowledged that a picture should have been taken the same day. The ADOC acknowledged that a picture of the skin impairment should have been taken on the same day and not 15 days after.

Sources: CI #2468-000017-21, a resident's clinical records, home's policy **"**Skin and Wound Assessment, G-35-10" revised date June 2, 2021 and staff interviews.

[708239]

2. Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
The licensee has failed to comply with the process to assess a resident's altered skin integrity.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment, and must be complied with.

Specifically, staff did not comply with the home's policy **"**Skin and Wound Assessment in PCC, RCS G-35" revised June 23, 2022, which was included as part of the licensee's Skin and Wound Care Program.

Rationale and Summary

The home's policy **"**Skin and Wound Assessment in PCC" directed registered staff to assess the skin impairment immediately using the PCC Skin and Wound Application, and a picture should be taken during the initial Wound Assessment.

A written complaint was forwarded to the MLTC by the home regarding a resident's skin condition. On an identified date, the family notified the staff about the resident's skin impairment.

Staff acknowledged that the required assessment was not completed when it was brought to their attention and admitted that they completed the initial wound assessment the following day.

The ADOC acknowledged that staff was required to take a picture and complete the initial wound assessment of the skin impairment on the same shift it was identified.

Sources: CI #2468-000030-22, a resident's clinical records, home's policy **"**Skin and Wound Assessment in PCC, RCS G-35" last revised June 23, 2022 and staff interviews.

[708239]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard). Specifically, additional requirements 9.1 (b) under the IPAC Standard required the licensee to ensure hand hygiene, including, but not limited to, at the four moments of hand hygiene.

Rationale and Summary

A staff was observed administering medications then prepared medications for a different resident. The staff did not perform hand hygiene between these activities.

Staff and ADOC both acknowledged that staff were required to perform hand hygiene when administering medications in between residents.

The home's policy titled "Hand Hygiene and Gloves Use, IFC H-15" directed staff to perform hand hygiene according to the four moments of hand hygiene, including before and after resident/resident environment contact.

Failure to ensure hand hygiene was performed according to Routine Practices increased the risk of infectious disease transmission.

Sources: Observations in the home, the home's policy titled "Hand Hygiene and Gloves Use, IFC H-15" last revised August 19, 2022 and staff interviews.

[708239]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs stored in a medication cart was secure and locked.

Rationale and Summary

A medication cart was left unattended and unlocked in the hallway, while the nurse was observed going in and out of a resident lounge to administer medications.

The nurse acknowledged that they were expected to lock the medication cart when it was left unattended. The ADOC acknowledged that medication carts should be kept locked when not in use.

They both acknowledged that when the medication cart was left unlocked and unattended, there was an increased risk that residents could access any of the drugs stored within it.

Sources: Observations in the home, Policies & Procedures: Manual for MediSystem Serviced Homes, Section 18: Medication Administration updated June 2022 and staff interviews.

[708239]