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

Original Public Report

Report Issue Date: June 28, 2023
Inspection Number: 2023-1073-0005
Inspection Type: Critical Incident System
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Eatonville Care Centre, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Nital Sheth (500)	Nital Sheth Digitally signed by Nital Sheth Date: 2023.06.29 08:46:47 -04'00'

Additional Inspector(s)
Michael Chan (000708)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 15-16, 19-22, 2023.

The following intake(s) were inspected:
- Intake #00022721 related to injury not related to fall
- Intake #00084547 related to fall incident resulting in injury
- Intake #00089550 related to incompetent care resulting in hospitalization and change in condition
- Intake #00089857 related to improper transferring techniques resulting in injury

Intake #00017834 related to fall incident resulting in injury was completed as a result of this inspection.

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
The resident's plan of care indicated that they require a certain level of assistance during a transfer. A staff transferred a resident inappropriately according to the resident's plan of care. During this transfer, the resident sustained injury and was sent to the hospital for further assessment.

Failure of the staff to use safe transferring techniques, resulted in the resident sustaining injury and being transferred to the hospital.

Sources: The home's investigation record, the resident clinical record, interviews with the home's staff and management, Policy (Using identified devices safely, reviewed Date: Jun. 27, 2022), Policy (Resident Care and Services- identified devices, revised May 26, 2023). [000708]

COMPLIANCE ORDER CO #001 Plan of Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate all registered staff who work on an identified unit, on the implementation of any orders written by the physicians or Nurse Practitioner (NP) for residents.
2. Review importance of monitoring residents for implementation of treatment for specified care with all registered staff working on the identified unit.
3. Maintain a record of the education conducted, including the date, staff attendance, who provided the education and content of the education.

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

Rationale and Summary
The home submitted a Critical Incident System (CIS) report regarding an incident of improper/incompetent treatment of a resident which resulted in harm or risk to the resident. The resident had a change in their condition. The Nurse Practitioner (NP) assessed the resident to be experiencing an acute health condition and ordered a specific treatment. Registered staff did not initiate the treatment until 12 hours later. The resident was transferred to the hospital due to a decline in their condition and subsequently passed away.

Failure to implement the specific treatment as ordered by the NP in a timely manner, placed the resident at further risk and impact to their health status.

Sources: The resident clinical records, CIS, home's investigation notes; and interviews with PSW #109, Registered Nurse (RN) #114, #115, #118, NP and Director of Care Acting (DOC-A) [500]

This order must be complied with by July 21, 2023

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.