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: May 17, 2024

Inspection Number: 2024-1073-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Rykka Care Centres LP

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

Lead Inspector	**Inspector Digital Signature**
Ryan Randhawa (741073)	Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2024.05.23 14:08:33 -04'00'

Additional Inspector(s)
Matthew Chiu (565)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15-19, 22-23, 25-26, 29, 2024 and May 1, 2024 with April 15-19, 22-23, 25-26, 29, 2024 and May 1, 2024 conducted on-site and May 6, 2024 conducted off-site.

The following intake(s) were inspected in this Critical (CI) inspection:

- Intake: #00108483 - [CI: 2468-000008-24] - was related to improper/incompetent care
- Intake: #00110631 - [CI: 2468-000015-24] - was related to injury of unknown cause
- Intake: #00110656 - [CI: 2468-000014-24] - was related to abuse
- Intake: #00111104 - [CI: 2468-000016-24] - was related to abuse
- Intake: #00111659 - [CI: 2468-000018-24] - was related to outbreaks

The following intakes were inspected in this complaints inspection:

- Intake: #00108457 - was related to skin and wound management and neglect

The following intake(s) were completed in this CI inspection:

- Intake: #00109669 - [CI: 2468-000012-24] - was related to outbreaks

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated

and are consistent with and complement each other

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Rationale and Summary

A resident developed skin impairment. Staff completed an assessment, applied a pro re neta (PRN) cream to the affected areas and left a note in the physician's binder.

The home's policy "Skin Impairment Assessment in PCC" directed registered staff to assess the skin impairment and stated that "the physician or Nurse Practitioner (NP) will be informed of all new wounds, obtaining a treatment order during the call."

A registered Practical Nurse (RPN), registered Nurse (RN), Wound Care Lead and an Assistant Director of Care (ADOC) indicated that the physician and the NP were not notified and that the staff should have collaborated with the physician or the NP for their assessment of the resident's skin impairment.

The NP was informed of the skin impairment and assessed the resident and ordered treatment for the skin impairment two days later. An RPN, Wound Care Lead and an ADOC acknowledged that had the staff collaborated with the physician or the NP when the skin impairment was first discovered, the appropriate assessments and interventions could have been provided to the resident to implement the interventions in a more timely manner.

There was a delay with the resident receiving an assessment and appropriate interventions to treat their skin impairment and an increased risk of skin breakdown when the interdisciplinary team did not collaborate in their assessment of the resident's skin impairment.

Sources: Critical Incident Report # CI: 2468-000008-24; resident's clinical records; investigation notes; home's policy "Skin Impairment Assessment in PCC", RCS G-35, revised June 9, 2023; interviews with RPN, RN, Wound Care Lead, ADOC and other staff.
[741073]

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)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the appropriate level of assistance related to specific personal care was provided to a resident as specified in the plan.

Rationale and Summary

A resident's care plan indicated that they required a specific level of assistance for specific personal care.

A PSW was observed providing the incorrect level of assistance for the specific personal care.

The PSW acknowledged that they should have provided the level of assistance as indicated in the plan of care. An ADOC and the Director of Care (DOC) indicated that the expectation was that the staff follow the care plan for the resident and provide the specified level of assistance for the specific personal care.

The resident was at increased risk of injury when the specified level of assistance for the specific personal care was not provided to the resident as specified in the plan.

Sources: Resident's clinical records; observations; interviews with PSW, ADOC and DOC, and others.
[741073]

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)
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 licensee has failed to ensure that resident #002 was protected from verbal abuse by resident #003.

Rationale and Summary

For the purposes of the definition of "abuse", "verbal abuse" means any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

Record review and staff interviews revealed that resident #003 demonstrated an understanding and appreciation of the consequences of their verbal comments. Staff witnessed that the resident #003 made verbally abusive comments to resident #002. Resident #002 subsequently reported to staff that resident #003 had also made other aggressive comments causing them to fear for their safety in the presence of resident #003. The DOC confirmed the incident and acknowledged the failure in protecting resident #002 from verbal abuse by resident #003.

The non-compliance led to resident #002 experiencing fear and distress within the home.

Sources: Resident's progress notes; interviews with the two residents; interviews with PSW, RN, and the DOC.
[565]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when a person had reasonable grounds to suspect abuse of resident #002 had occurred or might have occurred, they immediately reported the suspicion to the Director.

Rationale and Summary

a. Record review and staff interviews revealed that on three days, resident #003 was observed demonstrating verbal abuse towards resident #002. Staff interviews confirmed that these events constituted reasonable grounds to suspect that verbal abuse toward resident #002 by resident #003 had occurred. The RN evening supervisor confirmed, and the DOC acknowledged, that these incidents were not reported to the Director as required.

b. Record review and staff interviews revealed that on a different day in the next month, staff witnessed resident #003 being verbally abusive to resident #002. Resident #002 subsequently reported to staff on the same day that they feared for their safety in the presence of the resident #003. Further interviews with staff members and the DOC confirmed that the incident constituted verbal abuse toward resident #002 by resident #003 and that it was not reported to the Director immediately but on the following day.

Failure to report the abuse to the Director did not place residents at risk.

Sources: Resident's progress notes; CIS report #2468-000014-24; interviews with RPN, RN, RN evening supervisor, and the DOC.
[565]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that the Minister's Directive: COVID-19 response measures for long-term care homes, was complied with.

In accordance with the Directive, the licensee was required to follow the MLTC COVID-19 guidance document for long-term care homes in Ontario.

Rationale and Summary

The COVID-19 guidance document for long-term care homes required the licensee to complete infection prevention and control (IPAC) audits weekly when the home was in outbreak, which included the Public Health Ontario's (PHO's) COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes LTCH and Retirement Homes.

The long-term care home was in outbreak for COVID-19 from January 3 to January 29, 2024. The PHO COVID-19 Self-Assessment Audits were not completed for the week of January 14, 2024 to January 20, 2024 as the audits

were completed on January 12 and the next one on January 21, 2024.

The IPAC Lead acknowledged that the PHO COVID-19 Self-Assessment Audit Tool for Long Term Care Homes and Retirement Homes was not completed at a minimum, weekly when in outbreak.

Failing to conduct the required IPAC audits affected the long-term care home's ability to monitor, implement and evaluate the home's IPAC program. There was low risk to residents when the IPAC self-assessment audit tool was not completed weekly when the home was in outbreak as the IPAC practices were still in place in the long-term care home.

Sources: Review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022; MLTC COVID-19 guidance document for long-term care homes in Ontario, published May 04, 2021; completed PHO's COVID-19: Self-Assessment Audits dated January 12, 2024 and January 21, 2024; and interview with IPAC Lead, and DOC.
[741073]

WRITTEN NOTIFICATION: Foot care and nail care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee failed to ensure that a resident received appropriate specified

care.

Rationale and Summary

A family member noted an issue with the resident's care.

The home's policy "Personal Hygiene and Grooming" indicated that the specified care will be provided to each resident in accordance with the care plan. The policy stated that the specified care will be provided as part of their shower/bath routine and that PSWs will provide routine specified care weekly on one of the bath days as assigned.

The resident's care plan indicated that staff were to complete the specified care on a specified day of the week.

A PSW who worked on the day the family member visited, indicated that the area for the specified care appeared ungroomed.

The documentation survey reports for the resident indicated that the resident last had the specified care 29 days ago. No documentation of the specified care was noted for 29 days. Two PSWs, who showered the resident acknowledged that they did not perform the specified care on the resident during the course of the 29 days, as indicated in the documentation report.

The DOC indicated that the resident should have been having the specific care provided on a specific day of the week, as indicated in the resident's care plan.

Failure to consistently provide specific care to the resident increased the risk

of poor hygiene and infection.

Sources: Resident's clinical records; the home's policy titled "Personal Hygiene and Grooming", RCS D-05, revised March 13, 2023; interviews with PSWs, DOC, and others.
[741073]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) 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,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Rationale and Summary

A PSW noted that the resident developed skin impairment.

The home's policy "Skin Impairment Assessment in PCC" directed registered

staff to assess new skin impairments immediately using the Point Click Care (PCC) Skin & Wound Application.

The resident's clinical records indicated that no assessment or documentation for the skin impairment were completed when it was first discovered. The assessment of the skin assessment was completed the next day the skin impairment was noted.

A RPN, Wound Care Lead, an ADOC, and the DOC acknowledged that a skin and wound assessment was not completed for the skin impairment on the day it was first noted, and that it should have been completed when the skin impairment was first discovered.

Failure to complete a skin and wound assessment for the resident who exhibited alerted skin integrity put the resident at risk for not receiving the appropriate treatment promptly and further skin breakdown.

Sources: Critical Incident Report # CI: 2468-000008-24; resident's clinical records; investigation notes; home's policy "Skin Impairment Assessment in PCC", RCS G-35, revised June 9, 2023; interviews with PSW, RPN, Wound Care Lead, ADOC, DOC and other staff.
[741073]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps, including identifying and implementing interventions, were taken to minimize the risk of altercations and potentially harmful interactions between a resident and another resident.

Rationale and Summary

Record review and staff interviews revealed that resident #003 had a history of altercations and other interactions towards staff and residents. The other resident had interventions for these altercations. Resident #003 an intervention put in place but continued to demonstrate altercations.

After the intervention, staff observed that resident #003 exhibited altercations, particularly towards resident #002, on three shifts. The above-mentioned interventions were not revised to minimize the risk of potentially harmful interactions towards resident #002. Record review and staff interviews confirmed that no interventions were identified and implemented to minimize the risk of altercations and harmful interactions towards resident #002 by resident #003 until after another incident occurred the next month.

The non-compliance caused a lack of interventions to safeguard resident #002 from harmful interactions and jeopardized their well-being and safety in the home.

Sources: Resident's progress notes, care plan; interviews with the resident,

RPN, BSOL, and the DOC.
[565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC). The home has failed to ensure that the Hand Hygiene program was implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022." Specifically, support for residents to perform hand hygiene after toileting, as required by Additional Requirement 10.4 (h) under the IPAC standard.

Rationale and Summary

It was observed after a PSW assisted a resident with toileting, the PSW put soap and water on a paper towel and rubbed it on the resident's hands, fingers and fingernails and then put water on another paper towel and rubbed it on the resident's hands, fingers and fingernails.

The "IPAC Standard for Long-Term Care Homes April 2022" referred to the

Provincial Infectious Diseases Advisory Committee (Ontario) (PIDAC) document, "Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012", which described hand hygiene as being accomplished by using soap and running water or an alcohol-based hand rub (ABHR). The document defined hand washing as the physical removal of microorganisms from the hands using soap (plain or antimicrobial) and running water.

The home's hand hygiene policy indicated that the two methods of killing/removing microorganisms on hands were ABHR when hands are not visibly soiled, or hand washing with soap and running water when hands were visibly soiled.

The IPAC lead, an ADOC, and DOC acknowledged that the use of a paper towel with soap and water on it to wash the resident's hands after toileting did not suffice as proper hand hygiene. The IPAC lead indicated that the PSW should have used soap and running water if the resident's hands were visibly soiled or ABHR if their hands were not visibly soiled for the resident's hand hygiene after toileting.

Failure of the staff to support the resident in performing proper hand hygiene after toileting by using soap and running water or ABHR, increased the risk of infection transmission.

Sources: Resident's clinical records; observations; "IPAC Standard for Long-Term Care Homes April 2022"; "PIDAC Routine Practices and Additional Precautions in All Health Care Settings", 3rd Edition, November 2012; the home's policy titled "Hand Hygiene and Glove Use", IFC H-15, revised November 10, 2023; interviews with PSW, ADOC and DOC, and others.

[741073]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were recorded.

Rationale and Summary

The resident exhibited respiratory symptoms. The resident had a respiratory disease. The resident's clinical records showed no documentation or record of symptom monitoring on two shifts.

The IPAC lead and the DOC indicated that the expectation was that residents with infectious symptoms should have been monitored and their symptoms documented every shift. The IPAC Lead and DOC acknowledged that the recording of symptoms indicating the presence of infection was not completed for the resident on the shifts mentioned above.

There was increased risk that timely response to the resident's symptoms of

infection would not be communicated, and appropriate actions taken when their symptoms were not recorded every shift.

Sources: Review of the resident's clinical records; Line List for March 16, 2024 acute respiratory infection outbreak; interviews with RPN, IPAC lead, and DOC.
[741073]