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: February 8, 2024

Inspection Number: 2024-1073-0001

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**
Michael Chan (000708)	Michael K Chan Digitally signed by Michael K Chan Date: 2024.02.12 13:04:33 -05'00'

Additional Inspector(s)
Jack Shi (760)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30-31, February 1, 5-7, 2024.

The following Critical Incident intakes were inspected:

- Intake: #00102198 - 2468-000057-23 – Related to a fall with injury
- Intake: #00103803- 2468-000060-23 – Related to an injury from an unknown cause
- Intake: #00100265, 00105708 - 2468-000054-23, 2468-000001-24 – Related to diseases outbreak

The following Complaint intake was inspected:

- Intake: #00105120 – Related to multiple resident care concerns

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and 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)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that resident #001's care plan reflected the resident's assessed needs as it pertains to their falls prevention interventions.

Rationale and Summary
Resident #001's care plan stated to remind/encourage the resident to use a device, while also indicating that the resident was unable to use the device. Personal

Support Worker (PSW) #107 stated the resident was unable to use the device and acknowledged this was not an intervention that reflected the resident's current assessed needs. Assistant Director of Care (ADOC) #101 also acknowledged this upon review of the resident's care plan and amended the resident's care plan following their interview with the inspector to remove the encouragement and reminder for the resident to use this device.

Failure to ensure the resident's assessed care needs are reflected in their care plan may result in lack of effectiveness in the developed interventions for the resident.

Sources: Resident #001's care plan, interviews with PSW #107 and ADOC #101.

[760]

Date Remedy Implemented: February 1, 2024