Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: September 20, 2024
Inspection Number: 2024-1073-0003
Inspection Type: Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Eatonville Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27, 29, 30, 2024 and September 3-6, 9-11, 2024

The following critical incidents (CIs) were inspected:

- Intake: #00116054 – CI: #2468-000023-24 – Alleged neglect of a resident.
- Intakes: #00116978 & #00124091 CIs: #2468-000024-24 & #2468-000042-24 - Physical altercation between residents.
- Intake: #00120614 – CI: #2468-000035-24 - Resident-to-resident altercation resulting in abuse.
- Intake: #00123367 – CI: #2468-000041-24 - Unwitnessed fall of a resident resulting in injury.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and 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 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when care set out in the plan was not effective.

Rational and Summary

A resident sustained a fall with injury. A Personal Support Worker (PSW) heard commotion of a resident falling coming from their bedroom, upon their arrival the resident was found on the floor. The PSW indicated they did not hear the resident's safety device alert them the resident was trying to stand up.

Before the resident's fall staff were aware the resident had a history of turning off their safety device. The PSW indicated the resident had a history of sitting at the edge of their bed, and then turning off their safety device. Another PSW indicated they were informed by staff about the resident's history of turning off the safety device. A Registered Nurse (RN) indicted they were notified the resident was turning off their safety two days before their fall.
An Assistant Director of Care (ADOC) acknowledged the resident's intervention, specifically their safety device, was not effective and their plan of care should have been updated and revised.

Failure to reassess and revise a resident's plan of care when the care set out in the plan was no longer effective, placed the resident at an increased risk for injuries related to falls.

Sources: A resident clinical records, interviews with PSWs, RN and the ADOC.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 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 failed to ensure that an intervention was implemented for a resident to prevent altercations with other residents.

Rationale and Summary

A resident was identified as exhibiting responsive behaviour, an intervention was implemented to manage their responsive behaviours and prevent altercations. Resident #004 entered resident #005's room and had a physical altercation with the resident. PSWs and Registered Practical Nurse (RPN) acknowledged that resident #004 was not provided with an intervention at the time of the incident.

ADOC and Behavioral Support Ontario (BSO) Lead confirmed that resident #004

was not provided with the required intervention.

Failure to implement the required intervention increased the risk of resident #004 getting into physical altercations with other residents.

Sources: A resident's health records, interviews with PSWs, ADOC and BSO Lead.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

The home received a complaint from a resident's Substitute Decision Maker (SDM) concerning the care received by the resident. The home's written response to the complaint did not include Ministry of Long-Term Care (MLTC)'s toll-free number for

making complaints about homes and its hours of service and contact information for the patient ombudsman.

Executive Director acknowledged that the response letter to the SDM did not include the required information.

Failure to provide Ministry's toll-free telephone number for making complaints about home and contact information for the patient ombudsman did not place the resident at risk.

Sources: CIS #2468-000023-24 and interview with ED.