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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 21, 2023
Original Report Issue Date: August 15, 2023
Inspection Number: 2023-1073-0007 (A1)
Inspection Type: Follow up Critical Incident System
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Eatonville Care Centre,Etobicoke

Amended By	**Inspector who Amended Digital Signature**
Nital Sheth (500)	Nital Sheth Digitally signed by Nital Sheth Date: 2023.08.21 14:23:42 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to correct an error with a date identified in Non-Compliance (NC) #001.

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Lead Inspector Nital Sheth (500)	**Additional Inspector(s)** Trudy Rojas-Silva (000759)
Amended By Nital Sheth (500)	**Inspector who Amended Digital Signature** Nital Sheth Digitally signed by Nital Sheth Date: 2023.08.21 14:23:09 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to correct an error with a date identified in Non-Compliance (NC) #001.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 2-3, 4 (off-site), 8-9, 2023.

The following intake(s) were inspected:

- Intake #00090400 related to duty to protect
- Follow-up (F/U) intake #00091233 related to plan of care
- F/U intake #00091744 related to certification of registered nursing staff
- F/U #00091745 related to nursing and personal support Services

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1073-0005 related to FLTCA, 2021, s. 6 (7) inspected by Nital Sheth (500)

Order #002 from Inspection #2023-1073-0004 related to O. Reg. 246/22, s. 51 inspected by Nital Sheth (500)

Order #001 from Inspection #2023-1073-0004 related to FLTCA, 2021, s. 11 (1) (a) inspected by Nital Sheth (500)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report an allegation of staff to resident abuse.

Rationale and Summary
Resident #002 reported to Personal Support worker (PSW) an allegation of abuse by a staff member. PSW #114 observed resident #002 had a skin injury and reported it to Registered

Practical Nurse (RPN) #115. PSW #114 did not report the allegation of abuse made by the resident to RPN #115. Next day, resident #002's skin injury was reported to their Substitute Decision Maker (SDM). The SDM requested the home investigate the incident. The incident was not reported immediately to Director.

Failure to report the incident immediately, left resident #002 to be vulnerable to further potential abuse.

Sources: Record review of the home's Policy on Abuse and Neglect (Policy #RCS P-10, updated February 3, 2023), Interviews with PSW #114, and ADOC #103. [000759]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that, resident #002 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
PSW #114 reported to RPN #115 that resident #002 had a new skin injury. RPN #114 did not assess or immediately treat resident #002's skin injury, which went untreated until the following day.

Staff's failure to immediately assess and treat the skin injury resulted in untreated pain and left resident #002 at risk for other potential injuries.

Sources: Record review of the home's policy on Skin Impairment Assessment in PCC Policy #RCS G-35, updated on June 9, 2023, Interviews with RPN #115, and ADOC #103. [000759]