Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2014	2014_252513_0011	T-781-14	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

Long-Term Care Home/Foyer de soins de longue durée

EATONVILLE CARE CENTRE
420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 15, 18, 19, 2014.

During the course of the inspection, the inspector(s) spoke with personal service workers (PSW), registered staff, evening supervisor, director of nursing and personal care (DON), assistant director of nursing, physiotherapist, and administrator.

During the course of the inspection, the inspector(s) conducted a walk through of the identified unit, reviewed resident #1's clinical health record, reviewed the transfer policy, observed staff to resident and staff to staff interactions; and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that on a specified date, resident #1 was safely transferred on/off the wheelchair using a mechanical lift with two staff physical assistance.

On a specified date, the physiotherapy progress note stated the resident was assessed as non-weight bearing and the transfer status changed, from a two person physical assist to a two person mechanical lift, to ensure safety of staff and the resident. The care plan on a specified date, stated the resident was non-weight bearing and was to be transferred using a mechanical lift with two staff assistance on/off the wheelchair.

The progress notes on a specified date, stated the resident sustained an injury from an unknown cause and was transferred to hospital. The progress notes for a specified date, stated the resident received treatment for the injury. The home's investigation stated PSW #102 physically transferred the resident alone, out of and into bed, without the assistance of another staff and a mechanical lift. The PSW confirmed to being knowledgeable of the transfer method using a mechanical lift with two-person assist, as stated in the plan of care.

PSW #102, the evening supervisor and DON confirmed that the resident was transferred physically on two occasions by PSW #102 and not by using safe transferring techniques with two persons and a mechanical lift as stated in the plan of care. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring techniques when assisting residents, as identified in the plan of care, to be implemented voluntarily.

Issued on this 29th day of September, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs