



**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

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 10, 2013	2013_219211_0025	T-684-13	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**

**JOELLE TAILLEFER (211)**

**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): December 6, 9, 2013**

**During the course of the inspection, the inspector(s) spoke with administrator,  
assistant director of care, environmental service manager and maintenance staff**

**During the course of the inspection, the inspector(s) reviewed the critical  
incident report**

**The following Inspection Protocols were used during this inspection:  
Critical Incident Response**



**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**

---

**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 107. Reports re critical incidents**



**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**

---

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**

**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**

- i. a breakdown or failure of the security system,**
- ii. a breakdown of major equipment or a system in the home,**
- iii. a loss of essential services, or**
- iv. flooding.**

**O. Reg. 79/10, s. 107 (3).**

---

**Findings/Faits saillants :**

1. The licensee failed to inform the Director no later than one business day after a breakdown of a major equipment for a period greater than six hours.

On November 14, 2013, the licensee indicated that the south side heating unit was not functioning properly. The unit was shut off and an external technician was called. Record review and staff interview confirmed that the licensee notified the Director on November 19, 2013. [s. 107. (3)]

---

**Issued on this 10th day of December, 2013**

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