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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 24, 2015	2015_356618_0010	T-180-13;T-679-14;T-357-14	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

CECILIA FULTON (618)

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): July 22,23,24,27,28, 2015

This complaint inspection was conducted concurrently with: T-180-13,T-679-14,T-357-14

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), registered staff (RN,RPN), Personal Support Staff (PSW), Pharmacist, Residents, and Resident's family.
During the course of this inspection the inspector reviewed resident health records,records related to the homes training programs and attendance of training programs, Resident abuse and neglect policy, Resident abuse and neglect policy annual evaluation, quality management program related to falls.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Review of resident #3 progress notes and fall assessments revealed that they had suffered 10 falls since their admission. The fall assessment tool used by the home had identified resident as being at high risk for falls.
Review of plan of care created on 01/25/2012 for resident #3 and related to falls states that the resident has risk for falls and injury related to multiple risk factors such as use of psychotropic medications, unsteady gait and non-compliance with mobility aide use (attempts to ambulate without assistance).

The goals identified in this plan of care are: Zero preventable falls within 3 months.
The interventions identified in this plan of care are: Apply bed sensor while in bed and check every shift to ensure it is functioning.
Apply chair sensor to seat of wheelchair while up and check q shift to ensure it is functioning.
Check q 1 hr + PRN to ensure safety.
Ensure Call bell is within reach when in room, orientate to its position and reinforce its use to seek assistance as needed. Remind with each encounter.

A review of the Daily Resident Flow Sheet revealed that for the month of February 2014, floor mat use was checked daily and bed/Chair alarm use was checked daily.
Review of Daily Resident Flow sheet for the months of January 2014 and December and November 2013 revealed that floor mats use was not checked and bed/chair alarm use was not checked.
Review of Daily Resident Flow sheet for the month of October 2013 revealed that floor mat use was not checked and bed/chair alarm was checked for only 23 shifts and in the month of September 2013 floor mat use was checked for only 22 shifts and bed/chair alarm use was checked for only 26 shifts.

Interview with the DOC confirmed that documentation in the daily resident flow sheet is to be done to confirm that the intervention was observed as being in use. The DOC reviewed the documents in question for February 2015, January 2015 and December 2014 and confirmed the inspector's findings. [s. 6. (9)]

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Issued on this 24th day of August, 2015

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

Original report signed by the inspector.