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

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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
Feb 4, 2016	2016_340566_0002	036312-15	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

ARIEL JONES (566), SUSAN LUI (178), THERESA BERDOE-YOUNG (596), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 18, 19, 20, 21, 22, 25, 26 and 27, 2016.

The following Complaint Intake was inspected concurrently with this Resident Quality Inspection (RQI): #011800-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DONPC), assistant Directors of Care (ADOC), food service manager (FSM), physiotherapist (PT), social services worker, programs manager, environmental services manager (ESM), quality improvement coordinator, maintenance staff, registered nursing staff, personal support workers (PSWs), dietary aides, housekeeping aides, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, observed meal service, reviewed resident health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
1 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

Observations on January 18, 2016, revealed that the housekeeping supply door in the basement, which is equipped with a keypad lock, was propped open with a door stopper. A sign was posted on the door indicating that the door is to be closed and locked. Additionally, it was observed that the doors to the wheelchair storage room and the laundry/gas valve shut off room were also unlocked and not equipped with locks. These three doors were in the vicinity of the physiotherapy room, however, there were no residents or staff in the area at the time of observation.

An interview with the physiotherapist confirmed that some residents come to the basement independently to attend physiotherapy exercises. An interview with maintenance staff #110 confirmed the housekeeping supply door should be closed and locked when not in use. He/She could not identify whether the doors to the wheelchair supply room and laundry/gas valve shut off room should be locked.

During further observations on January 21, 2016, the housekeeping supply room door was again noted to be propped open with a door stopper, and the floor was wet. No staff or residents were in the vicinity. An interview with housekeeping aide #111 confirmed the door is to be closed and locked when not in use.

An interview with the environmental services manager (ESM) confirmed that the doors to the wheelchair supply room and laundry/gas valve shut off room have not been locked in the past and are not equipped with locks. The ESM agreed that all doors leading to non-residential areas are to be equipped with locks and kept closed and locked when they

are not being supervised by staff.

2. On January 18, 2016, inspector #178 observed an unlocked door to an unlabeled room (later identified as the janitor's closet) located on the main floor. This room contained wires, ladders, printer cartridges, a breaker panel and various wires, a deep low sink, and a large uncovered pail half filled with clear liquid. No staff were in the vicinity of the unlocked room. This same door was subsequently observed to be unlocked and unattended multiple times on January 20 and 21, 2016.

An interview with the ESM confirmed that the expectation is for the door to the janitor's closet to be kept locked when not in use. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

A record review of resident #001's clinical record indicated that the resident had identified

areas of altered skin integrity that developed in October 2015 and January 2016, and the plan of care included an intervention to turn/reposition the resident at least every two hours, and more often as needed or requested.

A review of resident #001's turning and repositioning record revealed missing documentation for three identified shifts in January 2016.

An interview with PSW #141 revealed that he/she worked the identified shifts, repositioned the resident every two hours with another staff member, and forgot to document this care on the resident's turning and repositioning record.

An interview with the DONPC confirmed there was missing documentation on the resident's turning and repositioning record for the identified shifts on the identified dates in January 2016, and the home's expectation is that repositioning of residents with impaired skin integrity should be documented on all shifts. [s. 6. (9) 1.]

2. A record review of resident #004's progress notes indicated that the resident developed an area of altered skin integrity in December 2015. Resident #004's care plan interventions included repositioning the resident every two hours to promote wound healing without complications.

An interview with PSW #142 revealed that he/she repositions resident #004, who is unable to reposition independently, every two hours, and does not document the repositioning as there is no turning and repositioning record in place for the resident. An interview with registered staff #143 confirmed that there is no documentation available to reflect that the resident was being repositioned every two hours as indicated in the plan of care.

An interview with PSW #144 revealed that he/she had been turning and repositioning resident #004 but had not been documenting on a turning and repositioning record as one had not been set up for the resident until the day of the inspector's interview with PSW #144.

An interview with the DONPC confirmed that turning and repositioning of resident #004 should have been documented on the turning and repositioning record, and was not. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On January 19, 2016, it was observed that resident #002's wheelchair seat cushion and foot pedals were soiled with food crumbs and stains. On January 21 and 22, 2016, the wheelchair was observed with a towel covering the seat cushion. The seat cushion was observed to be soiled with dried food stains. Furthermore, the wheelchair frame at the joints, brake area, and the inside of the wheel frame were observed to be covered with dried food debris.

On January 19, 2016, it was observed that the right armrest of resident #011's wheelchair and his/her identified positioning device were soiled with food debris. On January 20, 2016, the wheelchair frame was observed to be soiled with dried food debris and the wheels with dried mud. On January 22, 2016, resident #011's wheelchair was clean, however his/her positioning device remained soiled with dried food debris.

On January 19, 2016, it was observed that resident #012's wheelchair armrests were soiled with dried food debris. On January 21, 2016, the wheelchair armrests, hand brakes and frame were also observed to be soiled with dried food debris.

On January 21, 2016, the identified ambulation equipment for residents #002 and #012 were confirmed to be dirty by PSW staff #105, and #108 and #148, respectively. On

January 22, 2016, PSW #115 confirmed that resident #011's wheelchair was clean but his/her positioning device remained soiled.

Interviews with non-registered staff (#105, #108, #115, and #148), registered nursing staff members (#104, #107) and ADOC #102 revealed that it is the responsibility of the night PSWs to clean personal ambulation equipment according to a wheelchair cleaning schedule on each unit, as needed and if found soiled. PSW #115 and ADOC #102 confirmed that positioning devices should also be cleaned as needed, if found soiled.

A review of the cleaning schedules revealed that personal ambulation equipment is cleaned on a weekly basis. All of the identified wheelchairs were signed off as having been cleaned as per their previous weekly schedules.

On January 22 and 25, 2016, it was confirmed by ADOC #102 that the personal ambulation equipment for the identified residents was dirty and the expectation is for personal ambulatory equipment and positioning devices to be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

On January 18, 2016, the following observation was made:
Second Floor - large shower room:
- broken radiator leg with broken/missing floor tiles underneath.

On January 19, 2016, the following observations were made:
Second floor:
- Leak under the bathroom sink; sink faucet running and would not shut off in resident room #263.

Fourth floor:
- Loose grab bar in the bathroom of resident room #457.

An interview with nursing staff #109 revealed that he/she was not aware of the loose grab bar in the bathroom of resident room #457. Registered staff #109 accompanied the inspector to the identified bathroom and confirmed that the grab bar was loose.

On January 20, 2016, the following observations were made:

Second Floor - large shower room:
- The radiator leg was repaired; the floor tiles beneath the radiator were broken leaving a gaping hole in the floor.

On January 21, 2016, the following observations were made:
Second Floor:
- The sink faucet in the bathroom of room #263 was dripping and would not shut off, and
- wet paper towels were around the base of the toilet, and wedged between the pipes and the wall under the bathroom sink.

An interview with housekeeping aid #106 confirmed that he/she was aware of the dripping faucet that would not turn off in the bathroom of resident room #263 and did not notify maintenance. An interview with the registered staff #114 confirmed there was no maintenance request submitted for the running faucet and leaking sink.

On January 22, 2016, the above observations were confirmed by the ESM who stated that the expectation is for the home to be maintained in a good state of repair. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

As per section 79(3)(k) of the Long Term Care Homes Act (LTCHA), the required information to be posted includes copies of the inspection reports from the past two years for the long term care home.

Observations during the initial tour of the home on January 18, 2016, revealed that the following inspection reports from within the past two years were not posted in the home: 2015_356618_0009, 2015_378116_0009, and 2014_159178_0021.

As per section 79(3)(q) of the LTCHA, other information required to be posted in the home as per regulation 225(1)(4) of the Regulations includes the Ministry's toll-free telephone number for making complaints about homes and its hours of service.

Observations during the initial tour of the home on January 18, 2016, revealed that the Ministry's toll-free telephone number for making complaints about homes and its hours of service was not posted within the home.

An interview with the home's Administrator confirmed the above mentioned inspection reports and the Ministry's toll-free telephone number for making complaints about homes and its hours of service were not posted in the home. [s. 79. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is restrained, the resident is monitored at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

On January 21, 2016, the inspector observed resident #001 lying in bed with two side rails in the upright position.

An interview with PSW #141 revealed that he/she was assigned to resident #001 on two identified shifts in January 2016, and did not monitor the resident every hour while he/she was in bed with two side rails up.

A record review of the physician's orders revealed an order for the restraint: two side rails up when in bed. A review of the care plan for resident #001 directs staff to monitor the resident every hour while using two side rails in the upright position.

An interview with the DONPC revealed that the home's expectation is that PSW staff should monitor resident #001 every hour while he/she is in bed using the two side rail restraint on all shifts. [s. 110. (2) 3.]

2. The licensee has failed to ensure that every release of the device and repositioning of the resident are documented.

A record review of resident #001's plan of care and his/her physician's orders indicated the use of restraints: two side rails up while in bed, check every hour, and reposition every two hours, if awake. A record review of resident #001's restraint monitoring record revealed that there was no documentation for the two identified shifts in January 2016.

A record review of the home's policy entitled Restraints (index I.D. RCS E-25, dated May 1, 2014) directs PSW staff to monitor the resident's safety, comfort and position of the physical restraint every hour, and to release the physical device and reposition the resident every two hours.

An interview with PSW #141 revealed that he/she had forgotten to document his/her monitoring and repositioning of resident #001 while he/she was in bed using side rail restraints on two identified shifts in January 2016.

An interview with the DONPC confirmed that PSW staff are expected to complete documentation on the restraint monitoring record that they have visually monitored residents using restraints every hour and repositioned them every two hours, and that PSW #141 did not complete the required documentation on the identified shifts in January 2016. [s. 110. (7) 7.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided training in skin and wound care.

A record review of the home's skin and wound care training records from 2014, and an interview with the home's ADOC #102 confirmed that 80 per cent of registered staff were not trained in skin and wound care in 2014. [s. 221. (1) 2.]

Issued on this 4th day of February, 2016

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

Original report signed by the inspector.