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

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5700 Yonge Street 5th Floor
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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 3, 2016	2016_417178_0003	013782-15	Complaint

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 26, 27, 29, 2016

The inspector was on site from January 18-22 and January 25-27, 2016, for the purpose of conducting the home's Resident Quality Inspection (RQI) (inspection #2016_340566_0002).

During the course of the inspection, the inspector(s) spoke with a resident, a resident's family, an identified Assistant Director of Care (ADOC).
During the course of the inspection the inspector also made observations of a resident, and reviewed the following:
-resident records, including plan of care, progress notes and diagnostic reports.
-notes regarding the home's investigation into the incident.
-the home's training records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 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 has failed to ensure that staff uses safe transferring and positioning devices or techniques when assisting residents.

Interview with an identified family member of resident #001 confirmed that in May of 2015 the resident sustained an injury, requiring transfer to hospital for assessment and treatment. According to the family member, the home investigated the incident and concluded that the injury happened while the resident was being lifted incorrectly by a personal support worker (PSW).

Interview with the home's Assistant Director of Care (ADOC) #100 confirmed that the resident was transferred independently by PSW #101 without the use of a mechanical lift, and that this likely was the cause of the resident's injury. ADOC #100 confirmed that as per resident #001's plan of care, the resident required transfer using a mechanical lift.

Review of the resident's plan of care confirmed that the resident cannot weight-bear and requires the assistance of a mechanical lift with two staff members for transfer. Review of the home's notes of their investigation into the incident indicated that PSW #101 admitted that he/she transferred the resident from the shower chair to bed by lifting the resident up independently, without the assistance of other staff and without the use of a mechanical lift. The home's investigation notes also state that when interviewed at the time of the injury, resident #001 stated that he/she became injured while being transferred to bed independently by PSW #101.

Interview with ADOC #100, and review of the home's investigation notes confirm that PSW #101 was terminated after the investigation into the incident.

The home was previously found to be in non-compliance with this requirement on September 12, 2014 (Critical Incident Inspection # 2014_252513_0011), regarding a resident who sustained an injury after being lifted unsafely and not according to the resident's plan of care. A Voluntary Plan of Correction was issued at that time. During the present inspection one resident was affected. The resident sustained injury resulting in pain, requiring transfer to hospital for assessment and treatment. Based on the severity of the outcome for the resident, and the home's history with failing to lift safely, a compliance order is warranted. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm has occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).

Interview with ADOC #100 confirmed that resident #001 sustained an injury when he/she was transferred improperly by PSW #101. ADOC #100 confirmed that PSW #101 transferred the resident from the shower chair to bed independently, with no assistance, even though the resident's plan of care stated that the resident required a mechanical lift and two staff assistance for transfers. ADOC #100 confirmed that transferring the resident independently was improper and incompetent care.

Review of the Critical Incident System (CIS) revealed that the home had not reported the incident to the Director under the LTCHA.

ADOC #100 confirmed that the incident was not reported to the Director under the LTCHA. [s. 24. (1)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178)
Inspection No. / No de l'inspection :	2016_417178_0003
Log No. / Registre no:	013782-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 3, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	EATONVILLE CARE CENTRE 420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	EVELYN MACDONALD

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff uses safe transferring techniques when assisting resident #001, and other residents.

This plan should include, but is not limited to, methods for monitoring front line staff to ensure that they comply with residents' individual plans of care.

The plan shall be submitted via email to susan.lui@ontario.ca by February 28, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that staff uses safe transferring and positioning devices or techniques when assisting residents.

Interview with a family member of resident #001 confirmed that in May of 2015 the resident sustained an injury requiring transfer to hospital for assessment and treatment. According to the family member, the home investigated the incident and concluded that the injury happened while the resident was being lifted incorrectly by a personal support worker (PSW).

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bear and requires the assistance of a mechanical lift with two staff members for transfer. Review of the home's notes of their investigation into the incident indicated that PSW #101 admitted that he/she transferred the resident from the shower chair to bed by lifting the resident up independently, without the assistance of other staff and without the use of a mechanical lift. The home's investigation notes also state that when interviewed at the time of the injury, resident #001 stated that he/she became injured while transferred to bed independently by PSW #101.

Interview with ADOC #100, and review of the home's investigation notes confirm that PSW #101 was terminated after the investigation into the incident.

The home was previously found to be in non-compliance with this requirement on September 12, 2014 (Critical Incident Inspection # 2014_252513_0011), regarding a resident who sustained an injury after being lifted unsafely and not according to the resident's plan of care. A Voluntary Plan of Correction was issued at that time. During the present inspection one resident was affected. The resident sustained injury resulting in pain, requiring transfer to hospital for assessment and treatment. Based on the severity of the outcome for the resident, and the home's history with failing to lift safely, a compliance order is warranted. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

Service Area Office /
Bureau régional de services : Toronto Service Area Office