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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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, 2017	2016_440210_0017	031327-16	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

SLAVICA VUCKO (210), CECILIA FULTON (618)

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): November 22, 23, 24, 25, 28, 29, 30, December 1, 2, 2016.

The following complaint inspections were conducted concurrently with the RQI: 004267-14 (related to continence care, nutrition and hydration, restraints, plan of care, availability of supplies, 24-hour nursing, housekeeping, falls prevention), 030065-15 (related to residents' bill of rights), 007628-14 (related to safe and secure home), 017716-15 (related to personal support services), 026464-15 (related to personal support services and residents' bill of rights).
The following critical incident inspections were conducted concurrently with the RQI: 032345-16 and 032849-16 (related to transferring and positioning technique).
The following order 004627-16 (related to personal support services) was followed up.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), Resident Assessment Instrument (RAI) coordinator, registered dietitian (RD), physiotherapist (PT), environmental service manager, (ESM), registered nursing staff, personal support workers (PSWs), residents' substitute decision makers (SDMs), residents, Residents' Council president and Family Council president.

During the course of the inspection, the inspectors(s) conducted a tour of the home, observed medication administration, staff to resident interactions and the provision of care, resident to resident interactions, and reviewed resident health care records, staff training records, Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2016_417178_0003	210

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to Critical Incident Report (CIR) submitted to Ministry of Health and Long Term Care (MOHLTC), on November 09, 2016, at 2000 hours, resident #018 was transferred from the wheelchair to the bed with the mechanical lift by one staff. The transfer was witnessed by another person and reported to home's staff.

A review of the resident #018's care plan related to transfers revealed the resident was non-weight-bearing and staff was supposed to provide two persons extensive physical assistance with mechanical lift. A review of home's investigation notes and PSW #121's interviews had indicated the staff did not transfer resident #018 with two people assistance because a family member requested the resident be provided identified personal care immediately. Staff #121 had indicated that another staff was in the proximity but did not actively participate in the transfer. A review of the clinical record indicated the resident did not suffer ill effect. An interview with the DOC and review of staff #121's file indicated he/she was re-educated and disciplined.

An interview with the DOC revealed when the family member requested from the staff the resident to be cleaned, the staff should have transferred resident #018 with assistance of two people and confirmed that the care plan was not followed. [s. 6. (7)]

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 the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy "Resident Hydration" is complied with.

According to a Critical Incident Report (CIR) submitted to MOHLTC on an identified date, resident #017 had a fall and was transferred to hospital for treatment of a body injury. A review of resident #017's progress notes revealed on an identified date approximately two weeks after the fall, the resident was transferred to hospital again. A review of the hospital discharge summary revealed resident #017 was presenting with worsening health status. A review of resident #017's daily food and fluid intake flow sheets indicated an identified daily hydration goal. The fluid intake for an identified period of time revealed the resident had consumed less than 60% of the daily hydration goal on seven dates.

A review of the home's policy "Resident Hydration", RCS C-40, from September 4, 2013, revealed registered staff will initiate a dietary referral form for each resident who has not consumed their required amount of fluids for the 24-hour period over a three day time span once it is determined there is no particular reason for reduced consumption. An electronic progress note to be included in the residents chart identifying this action.

A review of resident #017's progress notes and interviews with registered dietitian (RD) and ADOC staff #121 confirmed when the resident did not meet the daily target for fluid intake for three days a referral to RD was not sent for further assessment. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that basic foot care services were received by the resident.

A complaint was submitted to the MOHLTC in regards to resident #016's toe nail care not being done for an unidentified period of time in 2015 resulting in the resident's toe nails being unkept.

Interview with personal support worker (PSW) staff #103 revealed that while he/she was providing care to the resident, he/she noted that the resident's toenails were long and were getting caught on his/her socks. The PSW had stated that this had been reported to the registered staff more than once because he/she thought the toe nail care was not part of the personal care duty.

A review of resident #016's written plan of care initiated on an identified date revealed that foot care, including the toenail trimming, was to be done on bath days.

A record review of resident #016's personal care flow sheets revealed no documentation that the resident received toenail trimmings in the specified period of four months. The inspector was not able to observe the resident because he/she was absent from the home.

A review of the home's policy "Foot Nail Care", # RCS G-95, dated November 19, 2013, revealed that routine and advanced foot care is to be provided to each resident. A foot care assessment is to be completed by registered staff to determine, on admission or after a health status change, if the resident requires routine or advanced foot care. According to the policy, routine foot care is provided by PSWs. PSWs are to provide routine foot nail care weekly on a bath day and document the care on a daily flow sheet. If there are any problems encountered, the PSW is to report to registered staff who will conduct a foot care assessment, documenting actions taken, including referrals to the physician or foot care nurse.

Interview with the DOC confirmed that resident #016 had been missed for the foot care services during a period of four months in a specified year. [s. 35. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has had a weight loss of five per cent of body weight, or more, over one month and any other weight change that compromises their health status was assessed using an interdisciplinary approach, actions are taken and outcomes are evaluated.

According to a Critical Incident Report (CIR) submitted to MOHLTC on a specified date, resident #017 had a fall and was transferred to hospital for treatment of a body injury. A review of the progress notes revealed the resident returned from hospital one week after, and was assessed by the RD. The RD note revealed that the resident had a weight loss of 10.3 per cent over the past six months. A review of the resident weight record from the following month revealed an additional five per cent weight loss. The resident was transferred to hospital again during the same month and returned one week after. A referral to RD was made after the second return from hospital.

A review of resident #017's progress notes and interviews with RD and ADOC staff #116 revealed that a referral to the RD is required when there is a monthly weight loss of five per cent or more and that no referral for further assessment was made on the month after the first assessment when further five percent weight loss was noted. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.