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 prévue 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

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
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Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Apr 18, 2019	2019_654618_0015	020369-17, 021658-17, 022854-17, 028378-17, 028662-17, 000402-18, 001615-18, 025252-18, 028084-18, 000880-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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): May 4, 5, 9, 10, 11, 12, 2018.

The following intakes were inspected during this inspection: 000880-19, CIS 2468-000002-19, 025252-18, CIS 2468-000019-18, 028378-17, CIS 2468-000024-17 related to falls management, 028084-18, CIS 2468-000020-18, 022854-17, CIS 2468-000022-17, #021658-17, CIS 2468-000018-17, related to plan of care, 020369-17, CIS 2468-000017-17, related to alleged abuse, 001615-18, CIS 2468-000003-18, 00402-18, CIS 2468-000001-18, related to injury of unknown cause

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), Registered Staff (RN/RPN), Personal Support Workers (PSW).

During the course of the inspection, the inspector observed the resident care areas, reviewed resident health care records, staffing schedules, and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 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	Légende 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 care set out in the plan of care was provided to the resident as specified in the plan.

A review of the Critical Incident System (CIS) report #2468-000022-17, dated in 2017, indicated that resident #004 did not receive care as specified in their plan of care.

According to the plan of care, resident #004 was to receive the identified care. Review of the electronic medication administration record (e-mar) identified that the order was signed off as administered on the identified date in 2017. However, according to the progress notes, the home's investigation, and the incident report of the event, the care was not administered as prescribed.

Interview with RPN #110, who had discovered that the prescribed care had not been delivered on the prior shift, provided information to what they had observed to the RN who completed the incident report form, dated in 2017. In an interview during this inspection, RPN #110 was not able to recollect the circumstances of this incident.

The home's investigation did conclude that the care had not been provided to the resident as prescribed. [s. 6. (7)]

2. A review of the CIS report #2468-000020-18, dated in 2018, indicated that resident #003 incurred an injury as a result of staff failure to follow their plan of care.

A review of the resident's written plan of care identified the level of assistance required when care was provided.

A review of the home's investigation notes identified that on an identified date in 2018, resident #003 had an injury when care was provided in a manner not consistent with the required level of care for this resident.

Interview with PSW #008, confirmed that while providing care to this resident, they left the bedside, leaving the resident with only one staff in attendance. PSW #008 was aware of the resident's plan of care, and confirmed that the plan of care was not followed.

Interview with resident #003, confirmed the events as described.

Interview with DOC confirmed that resident #003's plan of care was not followed as required. [s. 6. (7)]

3. A review of the CIS report #2468-000018-17, dated in 2017, indicated that staff failed to follow resident #005's plan of care.

A review of the resident's plan of care identified the level of assistance required when care was provided.

A review of the home's investigation into this incident included interviews taken at the time of the incident with the staff members involved, and concluded that the PSW involved in the incident provided care in a manner that was contrary to what is prescribed in the resident's plan. During delivery of the care, the resident incurred an identified injury.

Interview with RN #110, who was called to the room when this incident occurred, revealed that the PSW mentioned above had not followed the resident's plan of care on this occasion.

Interview with the DOC confirmed that resident #005's plan of care was not followed. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 25th day of April, 2019

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

Original report signed by the inspector.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CECILIA FULTON (618)
Inspection No. / No de l’inspection :	2019_654618_0015
Log No. / No de registre :	020369-17, 021658-17, 022854-17, 028378-17, 028662-17, 000402-18, 001615-18, 025252-18, 028084-18, 000880-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 18, 2019
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
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:

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

Ministère 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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for resident #003, is provided as specified in the plan.

Grounds / Motifs :

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

A review of the Critical Incident System (CIS) report #2468-000022-17, dated in 2017, indicated that resident #004 did not receive care as specified in their plan of care.

According to the plan of care, resident #004 was to receive the identified care. Review of the electronic medication administration record (e-mar) identified that the order was signed off as administered on the identified date in 2017. However, according to the progress notes, the home's investigation, and the incident report of the event, the care was not administered as prescribed.

Interview with RPN #110, who had discovered that the prescribed care had not been delivered on the prior shift, provided information to what they had observed to the RN who completed the incident report form, dated in 2017. In an interview during this inspection, RPN #110 was not able to recollect the circumstances of this incident.

The home's investigation did conclude that the care had not been provided to the resident as prescribed. [s. 6. (7)]
(618)

2. A review of the CIS report #2468-000020-18, dated in 2018, indicated that resident #003 incurred an injury as a result of staff failure to follow their plan of care.

A review of the resident's written plan of care identified the level of assistance required when care was provided.

A review of the home's investigation notes identified that on an identified date in 2018, resident #003 had an injury when care was provided in a manner not consistent with the required level of care for this resident.

Interview with PSW #008, confirmed that while providing care to this resident, they left the bedside, leaving the resident with only one staff in attendance. PSW #008 was aware of the resident's plan of care, and confirmed that the plan of care was not followed.

Interview with resident #003, confirmed the events as described.

Interview with DOC confirmed that resident #003's plan of care was not followed as required. [s. 6. (7)]
(618)

3. A review of the CIS report #2468-000018-17, dated in 2017, indicated that staff failed to follow resident #005's plan of care.

A review of the resident's plan of care identified the level of assistance required when care was provided.

A review of the home's investigation into this incident included interviews taken at the time of the incident with the staff members involved, and concluded that the PSW involved in the incident provided care in a manner that was contrary to what is prescribed in the resident's plan. During delivery of the care, the resident incurred an identified injury.

Interview with RN #110, who was called to the room when this incident occurred, revealed that the PSW mentioned above had not followed the resident's plan of care on this occasion.

Interview with the DOC confirmed that resident #005's plan of care was not followed. [s. 6. (7)]

The severity of this issue was determined to be a level 3, as actual resident harm did occur. The scope of the issue was a level 3, as it was identified as being widespread in three out of three resident's inspected. The home had a level 3, compliance history, that included:
A Voluntary Plan of Correction (VPC), issued in Inspection #2017_671684_0004, on October 10, 2017 and a VPC issued in inspection #2016_440210_0017, on February 3, 2017 (618)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 23, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of April, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Cecilia Fulton

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