Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 22, 2019	2019_766500_0021	013712-18, 022941-18, 001205-19	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

NITAL SHETH (500)

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): August 6, 8, 9, 12, 13, 14, 15, 19, 2019.

The intake logs #022941-18 (2468-000017-18) related to duty to protect, #001205-19 (2468-000004-19) related to safe transferring, and #013712-18 (2468-000009-18) related to duty to protect were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed the residents' care area, reviewed residents' records and home records.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff who provided direct care to resident #002 were kept aware of the contents of the resident's plan of care.

A review of the Critical Incident System (CIS) report indicated that on an identified day, Personal Support Worker (PSW) #104 did unsafe transfer of resident #002. The resident was required to be transferred by two staff members via an identified equipment. The resident was unable to stand and PSW called for help. The resident had no injury or complaint about pain.

A review of the resident's written care plan indicated that the resident required total assistance from two staff members for transferring using the identified equipment for all transfers.

Interview with PSW #104 indicated they were not aware of the resident's care plan. PSW #104 indicated that they just helped the resident when the resident asked for help with an identified care, during transfer the PSW identified that the resident was not able to stand and asked for help. PSW #104 acknowledged that it was their mistake and the resident's safety was compromised.

Interview with Registered Practical Nurse (RPN) #105, Registered Nurse (RN) #106, and Director of Care (DOC) indicated that PSWs are expected to be aware of the residents' plan of care and able to implement it.

This non-compliance is issued as the PSW was not aware of the resident's transferring needs and the resident's safety was compromised. [s. 6. (8)]

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 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: abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A review of the CIS indicated that on an identified day, resident #005 was seen by the physiotherapy (PT) aide exhibiting an inappropriate behaviour to resident #004. The CIS report indicated that it was reported a day later of the occurrence of the event to the MOLTC.

A review of resident #005's progress notes indicated the actual day of the incident.

The inspector was unable to interview PT aide, as they are no longer working in the home.

Interview with RN #107 and the DOC confirmed the incident and indicated that any alleged or suspected abuse should have been reported immediately to the MOLTC. [s. 24. (1)]

Issued on this 22nd day of August, 2019

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

Original report signed by the inspector.