Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 8, 2020	2019_526645_0019	017140-19, 021760-19	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

DEREGE GEDA (645)

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): December 17, 18, 19 and 20, 2019.

The following critical incidents with log #021760-19 (#2468-000031-19) related to fall prevention and management, and log #017140-19 (#2468-000022-19) related to fire and maintenance, were inspected.

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), Personal Support Workers (PSWs) and Residents.

During the course of the inspection, the inspector performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 the care set out in the plan of care was provided to the residents as specified in the plan.

Record review of a Critical Incident System (CIS) report submitted to the Ministry of Long Term Care (MLTC), indicated that resident#001 had an incident on an identified date and sustained an injury.

Record review of the progress notes documented on the day of the incident, indicated that the incident occurred when the resident was attempting to get out of their mobility device. The home completed a post incident assessment and developed interventions to prevent further incidents. The interventions included to keep communication devices within reach, put injury protection devices on the resident, and remove clutter to minimize further incidents.

On an identified date, Inspector #645 observed resident #001 sitting in their mobility device not wearing the injury protection devices. Interview with RN #100 confirmed the resident was not wearing the devices as specified in the plan of care.

Inspector #645 observed two additional residents, #002 and #003, to increase the resident sample due to identified noncompliance. Review of the plan of care for both residents, #002 and #003, directed staff members to apply the injury protection devices to prevent injuries.

On an identified date, resident #002 was observed in their room not wearing the devices. The Inspector called the primary PSW #101 and inquired about the injury protection devices. PSW #101 indicated that they forgot to put the devices on the resident and promised to put them on the resident as soon as possible.
On the same day, resident #003 was observed by the Inspector sitting in their mobility device not wearing the injury protection devices and the devices were stored on top of the bedside table. The resident was alert and oriented, and stated that staff members occasionally forget to apply them. They indicated that they sometimes try to remind staff members to apply the devices. Inspector attempted to contact the primary PSW, but they were not available.

Interview with Charge RN #103 confirmed that resident #003's injury protection devices were stored on the bedside table and the resident was not wearing them. The RN indicated that they were not sure why they were not applied. The RN confirmed that the plan of care for both residents, directed staff members to apply the devices to prevent injuries. They reiterated that staff members are expected to provide care as specified in the plan of care and confirmed that residents #002 and #003 did not receive care as

specified in the plan. [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 residents as specified in the plan,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Record review of a CIS report submitted to the MLTC, indicated that there was a fire incident on an identified date, causing an unplanned evacuation at the home.

Review of the home's fire incident investigation record indicated that the Toronto Fire Marshal and Fire truck #P445, arrived on scene to assist with the incident. The fire marshal determined the source of fire to be an electrical outlet in the kitchen area and shut off the designated breaker in the electrical panel. Further review of the records indicated that the fire marshal was unable to locate the specific breaker for the outlet immediately and contacted the home’s maintenance personnel #105 for assistance.

Interview with maintenance personnel #105 indicated that the fire marshal was unable to locate the breaker because some of the breakers in the electrical panel were not labelled. There were some breakers that were labelled but they were not legible. The maintenance personnel further indicated that the fire marshal recommended to relabel the electrical panel on the day of the incident, as it was not safe. Inspector #645 observed the electrical panel together with the maintenance personnel on an identified date, and the electrical panel was not relabeled as per the fire marshal's recommendations. The maintenance personnel confirmed that the labels were not done and promised to relabel them as soon as possible.

Interview with the Executive Director confirmed that the breakers in the electrical panel were not relabeled. They reiterated that leaving the breakers unlabelled poses risk and creates an unsafe environment for staff and residents. They indicated that they will have them relabeled immediately. [s. 5.]

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.