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
Jul 16, 2020	2020_833763_0010	004966-20, 006348-20, 009334-20, 010822-20	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

IANA MOLOGUINA (763)

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): June 3, 4, 5, 11, 12, 15, 16, 17, and 18, 2020.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

Log # 006348-20, CIS # 2468-000014-20, was related to falls,
Log # 004966-20, CIS # 2468-000012-20, was related to alleged abuse,
Log # 009334-20, CIS # 2468-000016-20, was related to alleged abuse, and
Log # 010822-20, CIS # 2468-000020-20, was related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOC), Canadian Armed Forces (CAF) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of this inspection, the inspector reviewed resident clinical records and conducted observations, including staff-resident interactions and resident care provision.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #033 was protected from emotional

abuse.

In reference to O. Reg. 79/10, s. 2 (1) (a), and subject to subsection 2 (1) of the Act, “emotional abuse” means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident System (CIS) report (#2468-000016-20) was submitted to the Ministry of Long-Term Care (MLTC) detailing an incident on a specified date, of an alleged staff abuse of resident #033. PSW #137, one of the Canadian Armed Forces (CAF) staff deployed to assist the home with resident care needs during the COVID-19 pandemic, was providing specified care with another home staff. PSW #137 checked on resident #033, who indicated to them and their colleague that they did not wish to be provided the indicated care. PSW #137 left the resident to re-approach at another time; however PSW #138, another staff member nearby who overheard PSW #137’s interaction with resident #033, went to resident #033 and abruptly removed resident #033’s blankets; they proceeded to provide the indicated care without consent and despite the resident grabbing at their blankets and waving their hands to indicate discontent.

The home’s investigation of the incident involving resident #033 concluded that PSW #138 did not follow the appropriate steps for obtaining consent when providing care to resident #033. They did not introduce themselves during care provision, and did not explain what care was to be provided prior to initiating the care.

PSW #137 was interviewed and confirmed that they reported the above incident information to the home as they felt resident #033 was treated poorly. PSW #137 confirmed they were providing care with another staff member at the time of the incident, and resident #033 declined to receive the indicated care. PSW #137’s partner agreed to leave resident #033 and come back later. However, PSW #138, who was providing care to resident #033’s neighbour at the time, approached resident #033, ripped the sheets off resident #033 without their consent and proceeded to check if the indicated care was required. PSW #138 recognized the indicated care was not required so they replaced the resident's bed sheets and left the resident.

ADOC #139 was interviewed and confirmed the incident involving resident #033 was reported to the home, and that PSW #138 was terminated after the incident. ADOC #139 indicated that PSW #138 was suspended pending an alleged abuse investigation related

to a previous incident, however they were mistakenly booked for a shift that resulted in the above incident.

Record review confirmed PSW #138 was erroneously scheduled for a shift on the specified date even though they were still on suspension after an earlier incident.

ADOC #139 confirmed the home failed to protect resident #033 from abuse on the specified date since the home should not have scheduled PSW #138 to work that shift. [s. 19. (1)]

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 resident #033 and all other residents are protected from emotional abuse, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.