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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
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Amended Public Report (A1)

Report Issue Date June 28, 2022
Inspection Number 2022_1073_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres LP

Long-Term Care Home and City
Eatonville Care Centre
420 The East Mall, Etobicoke, ON, M9B3Z9

Lead Inspector
Ivy Lam (646)

Inspector who Amended Digital Signature
Ivy Lam
2022.07.14 12:41:49 -04'00'

Additional Inspector(s)
Inspector #741073 (Ryan Randhawa) was also present during this inspection.

AMENDED INSPECTION REPORT SUMMARY

No amendment was made to this public report.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 31; June 1-3, 6-10, and 14, 2022.

The following intake(s) were inspected:

- Intake #000158-22 (CIS # 2468-000002-22) related to loss of essential services – elevators.
- Intake #000677-22 (CIS #2468-000003-22) related to improper care.
- Intake # 014074-21 (Complaint) related to skin and wound.
- Intake # 019766-21 (Complaint) related to resident care and enteral feed.
- Intake # 020328-21 (Complaint) related to pest control and elevator outages.

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The following **Inspection Protocols** were used during this inspection:

- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6(4)(a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident, so that their assessments were integrated, consistent with and complemented each other.

Rationale and Summary

According to the home's skin and wound assessment policy, registered staff were to assess all new skin impairments using the Point Click Care (PCC) skin and wound application, and inform the doctor to obtain an order. The Skin and Wound Lead was to assess each resident's wound weekly. A picture of the wound was to be taken during the initial and weekly wound assessments in PCC until the wound has resolved.

The resident returned from hospital with a wound. The initial skin and wound assessment was missed when the resident was readmitted to the home. No skin and wound assessment was done for the resident's wound until 104 days later.

Eleven days after their return, the Registered Nurse (RN) ordered a temporary treatment, and a referral was made to the Skin and Wound Lead to assess for appropriate dressing and interventions. The Skin and Wound Lead did not respond to the referral to assess the resident until 66 days after the referral.

The physician ordered a treatment for staff to continue to monitor. The resident's plan of care was not updated regarding the resident's wound care interventions until 158 days after the physician's order.

The Substitute Decision Maker (SDM) also indicated the specialist requested to see the home's weekly skin assessments/pictures of the resident's wound. Weekly skin assessments for the resident's wound began the next day, being 104 days after the resident returned to the home with a wound.

There was risk that timely and appropriate monitoring and treatment were not provided to resident #001 when the staff did not collaborate to assess and treat the resident's wound.

Sources: Review of the Home's Skin and Wound Assessment, Resident #001's progress notes, care plan, electronic Treatment Administration Records (eTAR), NPSTAT hospital notes, Skin and wound referral book, Physician's discharge summary report; Interviews with Registered Practical Nurse (RPN), Registered Nurse (RNs), Skin and Wound lead, the Director of Care (DOC), and other staff.
[646]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 12(1)1

The licensee has failed to ensure that all doors leading to stairways were kept closed and locked, were equipped with a door access control system that was kept on at all times, or were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

Rationale and Summary
The basement was accessible to residents.

The service elevator was used for all residents. Observations during the inspection showed the doors to the stairway by the service elevator, and the main stairway, both located on the ground floor, were unlocked, with the keypad system inactive and no audible door alarm. These stairways led from the ground floor to the basement. The basement doors were also unlocked with inactive keypad systems and no audible door alarms.

Further, there was no keypad or door access control system installed on the stairway near the service elevator from the ground floor to the basement.

The door to the main stairway from the ground floor leading to the upper floors did not have an audible door alarm and the door on the ground floor was held open.

The ED indicated there should be a door access system installed on the door on the stairway near the service elevator from the ground floor to the basement, and that all doors leading to stairways should be locked with a door access control system and audible alarms.

There was a risk to residents' safety and security when doors leading to stairways were not locked, and with no working door access control systems, and audible door alarms.

Sources: Observations of main stairwell door to basement, service elevator stairwell to basement, main stairwell to upstairs; Interviews with the receptionist and the Executive Director (ED).
[646]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 96(1)(a)

The licensee has failed to ensure that its operational systems, specifically their elevating devices, were maintained in good repair.

Rationale and Summary
A critical incident report and multiple complaints were received regarding the repeated outages of the home's elevator systems.

The home has six floors that are accessible by staff and residents, including the basement. The home is serviced by two elevators: A passenger elevator with a current capacity of two-persons, and a service elevator with a capacity of three-persons at the time of the inspection.

Both elevators were used by residents and staff members.

The home's elevator maintenance invoices for a six-month period, showed there were 35 work orders where the contractors conducted emergency maintenance service: 33 times for the front passenger elevator, and five times for the service elevator.

In the period above, the front passenger elevator was out of service for 17 days in April 2022, and for 13 days in May 2022. Overall, it was out-of-service and required contractor service for: 5 days in January; 4 days in February; 5 days in March; 23 days in April; 18 days in May; and 9 days in June 2022.

The service elevator was out of service and required contractor service for two days in January, and three separate times in June 2022.

The home was without a working elevator for two days in January, and for a shorter period on two different days in June 2022.

Between January to June 2022, elevator entrapment occurred six times, where a resident, and nine staff members were stuck in the passenger elevator.

Proposals for modernization of the passenger elevator were given to the home twice, about 10 and 15 years ago, but they did not proceed with the proposals.

The Director of Building Services acknowledged there was no plan to modernize the passenger elevator, and the long-term plan was to continue to repair the elevator when it breaks down. They were not aware about the entrapment of a resident and multiple staff members. They were uncertain about the lifespan of the home's passenger elevator, but admitted the elevators were highly used in comparison with other homes.

There was a safety risk to residents and an impact to resident quality of life with the continued breakdown of an essential service, when the elevators continue to breakdown, and old components are being used to maintain the elevators.

Sources: Critical Incident System (CIS) intake, Quality Allied Elevator emergency service elevator invoices, Elevator proposals for modernization, Technical Standards and Safety Authority (TSSA) reports; Observations and use of service and passenger elevators; Interviews with residents, Quality Allied Elevator Contractor Field Operations Manager, housekeeper/janitor, receptionist, the corporate Director of Building Services, ED, and other staff.
[646]

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 268(14)

The licensee has failed to ensure that staff were trained on the use of evacuation chairs, as a part of their emergency plans before they performed their responsibilities; and at least annually thereafter.

Rationale and Summary

As part of the home's emergency plan for loss of elevator service, evacuation chairs were to be used if residents were required to leave the floor for any reason.

A training video on use of evacuation chairs was provided to all staff on orientation and annually thereafter.

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PSWs, RPNs, and RNs indicated the training video was not adequate to prepare them to use evacuation chairs, as they did not know how to use the equipment. Staff had not received any hands-on training on use of the evacuation chairs.

The Staff Development Coordinator had received hands-on training on the use of the evacuation chair but needed practice to be comfortable using the evacuation chair. They indicated that in-person hands-on learning would be a more effective way for staff to learn the use of the evacuation chair.

Mock evacuations did not include the use of evacuation chairs.

There was a risk that staff may not be able to follow the home's emergency plan, and staff would not be able to assist residents off their units and out of the building, when necessary, given that staff have not received hands-on training to be able to use evacuation chairs in the home.

Sources: Review of Emergency Plan Manual – Code Grey – Loss of Elevator Service Policy, Evac+Chair Training Video, Surge Evac+Chair Training – video, Surge – Live Event – EVAC+chair Training; Observation of hands-on demonstration of evac+chair by Staff Development Coordinator; Interviews with Personal Support Workers (PSWs), RPNs, RNs, Staff Development Coordinator, and the ED.
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