Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Public Report

Report Issue Date: January 9, 2025

Inspection Number: 2024-1073-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Kindera Living Care Centres LP by its general partners, Kindera Living Care Centres GP Inc. and Kindera Living Management Inc.

Long Term Care Home and City: Eatonville Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 16-18, 20, 2024

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00125040 - [CI: 2468-000044-24] - Staff to resident physical abuse
- Intake: #00126535 - [CI: 2468-000050-24] - Neglect and improper care

The following complaint intake(s) were inspected:

- Intake: #00129135 - Infection Prevention and Control (IPAC), staff to resident abuse and residents' bill of rights

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Responsive Behaviours
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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

Rationale and Summary
The Nurse Practitioner (NP) assessed a resident and ordered a medication to be administered. The medication was not immediately available in the home.

On several days, nursing assessments showed a change to the resident's health condition. The NP was not informed despite the medication not being available.

A Registered Practical Nurse (RPN) indicated that they reported the outcome of their

assessment to a Registered Nurse (RN), and it was the RN's responsibility to communicate the outcome of the assessment to the NP. The RN acknowledged that they did not inform the NP of the outcome of the assessment. An additional RN acknowledged that they did not advise the NP when the intervention was not available.

Staff's failure to collaborate with the NP in the assessment of the resident put their health at risk.

Sources: Resident's clinical records; home's investigation note; and interviews with a RPN and RNs.

b) The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other, in the development and implementation of the plan of care.

Rationale and Summary
The NP gave a standing order for a medication to be administered to the resident.

The medication was not available and the NP was not informed when there was a change in the resident's health condition. No other actions were taken to manage the resident's health condition during this time.

Two RNs acknowledged that they did not advise the NP that the medication prescribed was not available.

Failure to collaborate with the NP in the implementation of intervention put the resident's health at risk.

Sources: Resident's clinical records; home's investigation note; and interviews with RNs and other staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with the home's procedure to promote zero tolerance of abuse of residents by not immediately notifying the police of an alleged incident of abuse.

Rationale and Summary
A resident alleged that staff was rough with them during care, resulting in injuries. Reports of the alleged incident of physical abuse were submitted by the home to the Ministry of Long-Term Care (MLTC).

The resident and their substitute decision-maker (SDM) asked a nurse not to notify the police. The home's Abuse and Neglect policy stated that the Executive Director/designate will immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident(s) that may constitute a criminal offence.

The DOC acknowledged that the police were not notified and they should have been.

Failure to notify the police of the alleged physical abuse incident risked not

protecting the resident's rights.

Sources: Home Abuse policy revision date June 27, 2024; resident's care record; and interview with DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies to respond to a resident's responsive behaviours were implemented.

Rationale and Summary
A Personal Support Worker (PSW) found a resident requiring care and calling for help.

The PSW said that the resident initially refused an intervention and then agreed. Prior to the intervention being implemented, multiple staff confirmed that the resident exhibited escalating responsive behaviours.

The resident's care plan included specific strategies for potential expressive behaviours related to refusing care.

After the intervention was implemented, the resident was observed with new

injuries later that day. A RPN, RN and DOC acknowledged that the strategies in the care plan for prevention of responsive behaviours were not implemented resulting in physical injury and emotional distress to the resident.

Failure to implement the strategies in the care plan to respond to responsive behaviours resulted in physical injury and emotional impact on the resident.

Sources: Resident care record; and interviews with a PSW, RPN, RN, and DOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that a written response provided to a person who made a complaint to the licensee concerning resident care included the Ministry's hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A written complaint alleging neglect of a resident was received by the licensee.

The home's response letter included the Ministry's toll-free telephone number for making complaints but did not include its hours of service and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The Executive Director (ED) acknowledged that the Ministry's hours of service and contact information for the patient ombudsman were omitted from the response in error.

Failure to provide the Ministry's office hours and contact information for patient ombudsman to the complainant may have limited their knowledge of additional avenues to address their concerns.

Sources: Review of CIS 2468-000050-24 and response letter; and interview with ED.