



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 sous la Loi de 2007 sur les foyers de soins de longue durée

**Health System Accountability and Performance Division
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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 31, 2013	2013_219211_0026	T-634-13, T-412-13	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 12, 13, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with director of care, assistant director of care, registered staff, personal support worker and resident's family

During the course of the inspection, the inspector(s) reviewed the critical incident report, clinical records, the home's abuse policy and observed provision of care

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

Legendé

WN – Written Notification

WN – Avis écrit

VPC – Voluntary Plan of Correction

VPC – Plan de redressement volontaire

DR – Director Referral

DR – Aiguillage au directeur

CO – Compliance Order

CO – Ordre de conformité

WAO – Work and Activity Order

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. (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 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :



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1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Health care record review and staff interviews indicate that an allegation of sexual abuse toward resident #2 from a visitor was reported by a staff on an identified date. The visitor was informed by the licensee about his/her visiting restriction. The assistant director of care interview revealed that a notice was left in the unit to inform the staff about the identified visitor's restriction. Registered staff interview confirmed that there was no notice left in the unit to inform the staff about the visitor's restriction. Health care record review and staff interviews confirmed that the resident's plan of care does not contain the information about the visitor's restriction [s. 6. (4) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 2nd day of January, 2014

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

Joelle Taillefer RN, BScW