Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Sep 4, 2014	2014_235507_0015	T-666-14	Complaint

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1

Long-Term Care Home/Foyer de soins de longue durée

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST, SCARBOROUGH, ON, M1L-1W1

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 24, 25, 28, 29, 31, and August 1, 5, 6, 7, 8, 11 and 12, 2014.

This inspection occurred concurrently with the resident quality inspection (RQI) report #2014_235507_0014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DORC), resident care manager (RCM), registered nursing staff, resident assistants (RAs), residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, conducted observation in care delivery processes, reviewed the home's records, policies and procedures, and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record in relation to the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Interview with an identified resident's family member revealed that he/she made complaints to the home in relation to the identified resident's care plan not being followed on an identified date, and other subsequent dates. Meetings have been held with the management team of the home in addressing the concerns.

Record review revealed and interview with the resident care manager (RCM) confirmed that the identified resident's family member did complain about the resident's plan of care not being followed. The home had a few meetings with the resident's family member to address the concerns, however, not all the family member's complaints were documented in the home's complaints record as required by the Regulations. [s. 101. (2)]

2. Record review revealed that numerous complaints (22) were received by the home from another identified resident's family member, within a period of one year. Among the above received complaints, only one was documented in the home's complaints record. Furthermore, it only included the date when the complaint was received, and the nature of the complaint. However, it did not include the description of the complaint, type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Interviews with the administrator and RCM confirmed that the home did not maintain a record of all received complaints for the second identified resident.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_235507_0014. [s. 101. (2)]

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 a documented record in relation to the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action,
time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of the care set out in the plan of care are documented.

Record review revealed that an identified resident requires checking and changing of his/her incontinent product twice per shift and as needed.

Interviews with registered staff and resident assistants (RAs) confirmed that the identified resident's incontinent product is changed two to three times per shift.

Record review of the documentation survey reports of the identified resident for a period of three months, revealed that the resident's incontinent product was not changed two to three times per shift consistently. For the first month of the 3-month period, the identified resident's incontinent product was changed only once during the day shift for 11 days; and was not changed or changed only once during the evening shift for 22 days. For the second month of the 3-month period, the resident's incontinent product was changed only once during the day shift for eight days; and was not changed or changed only once during the evening shift for 25 days. For the third month of the 3-month period, the resident's incontinent product was changed only once during the day shift for nine days; and was changed only once during the evening shift for 12 days.

Interview with the resident of care manager (RCM) and the director of resident care (DORC) confirmed that not all the changes of the identified resident's incontinent product are documented. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Record review of an identified resident's written plan of care indicates that the resident prefers to get up for breakfast and be back to bed after lunch, get up in the afternoon and return back to bed in the evening.

Interviews with the RAs confirmed that the identified resident is transferred to the chair either in the morning before breakfast until after lunch, or before lunch to the afternoon, if the family requests; otherwise the resident is put back to bed in the evening.

Interview with the identified resident's family member revealed that the resident was usually placed in the chair from mid-morning until the evening. without returning the resident back to bed for rest during the day.

Record review of the documentation survey reports of the resident for a period of three months, revealed that the resident was transferred once in the morning and once again in the evening daily.

Interview with the DOC confirmed that the identified resident's preferred rest routines are not supported. [s. 41.]

Issued on this 5th day of September, 2014

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