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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 21, 2016	2016_327570_0008	035785-15, 007546-16, 009066-16	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

SAMI JAROUR (570)

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): April 04, 05, 06, 07, 08, 11, 12, 13, 14 & 15, 2016

Complaint inspection Logs #035785-15 and #007546-16 related to fall causing injury, continence care, and sleep and rest patterns; Complaint inspection Log #0009066-16 related to fall causing injury and continence care; Complaint inspection Log #021238-15 related to medication administration and continence care, inspected by inspector #194 under inspection #2016_291194_0006; Critical Incident inspection Log #003212-15 related to fall with injury, inspected by inspector #570 under inspection #2016_327570_0009.

Non-compliance under O. Reg. 79/10, s. 107 (3) 4 was identified for Log #0009066-16 and will be issued under inspection report #2016_461552_0011.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Manager (RCM), Resident Assistants (RA), Registered Nurse (RN), Registered Practical Nurses (RPN), Informatics Specialist (Restorative Care Lead), Physiotherapist (PT), Physiotherapy Assistants (PTA), residents and family members.

Also observed staff to resident interaction, reviewed clinical health records of identified residents, reviewed relevant policies related to continence care, falls prevention, and staff-resident communication system.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6. (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan related to the use of a seatbelt alarm while in wheelchair.

Related to complaints Log #035785-15 and Log #007546-16 for resident #004

Resident #004 was admitted to the home with multiple diagnosis including cognitive decline.

Review of clinical records for resident #004 indicated the resident sustained a fall on an identified date and was transferred to hospital and diagnosed with an injury.

Two days following the fall incident, the home submitted a Critical Incidence Report (CIR) in relation to resident #004's fall. As per CIR, resident #004 was walking with PTA #125 in the hallway. At the end of hallway, resident #004 was asked to sit in the wheelchair when a co-resident was walking toward them. While PTA #125 was directing the co-resident, resident #004 stood up and fell. The PTA was not able to intervene before resident #004 reached the floor.

Review of plan of care for resident #004, in effect at time of fall, indicated the resident is at high risk of falls related to history of falls and decreased strength. The plan of care directs that seatbelt be in place.

Review of progress notes for resident #004 indicated, on an identified date seventeen days prior to fall incident, that resident #004 is able to undue the seatbelt and family is concerned that the resident will try to stand up and fall. Resident #004's daughter and POA consented to use a new Velcro seatbelt with alarm as it will alert staff that the resident is attempting to stand/transfer independently.

Review of physician orders indicated to use a Velcro closing seatbelt with wheelchair alarm; not a restraint as resident #004 is able to undue.

Interview with physiotherapist PT #124 indicated that PTA #125 involved in the fall incident is no longer in the home and that she/he had worked for one month prior to the incident. PTA #125 had all required orientation before assuming her/his job; she/he did one week shadowing with PTA #126; during this week PTA #125 assisted/walked

resident #004 with PTA #126. PT #124 confirmed that PTA #125 did not apply the Velcro closing seatbelt when she/he guided a co-resident away for a moment. PTA #125 was next to resident #004 but she/he did not see resident standing but saw resident falling and could not catch resident. PT #124 indicated that resident #004 has history of trying to stand from wheelchair before; the velcro closing seatbelt alarm was utilized for falls prevention due to self-transferring from wheelchair.

Interview with PTA #126 indicated to the inspector that resident #004 was a one person minimal assist for walking using mobility aid prior to the fall and needed support if losing balance and when turning. PTA #126 indicated using seatbelt for resident #004 when in wheelchair and during rest periods from walks.
PTA #126 confirmed to inspector that PTA #125 spent one week shadowing and that PTA #125 was instructed to apply seatbelt during rest periods from walking for resident #004.

Record review and staff interviews indicated that the Velcro seatbelt alarm was not applied while resident was resting in wheelchair during which PTA #125 redirected a co-resident. [s. 6. (7)]

2. The licensee failed to comply with LTCHA, 2007, s. 6. (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan related to transferring and toileting.

Related to complaint Log #009066-16 for resident #005

Resident #005 was admitted to the home with multiple diagnosis including cognitive decline.

On April 5, 2016, observation of resident #005's room indicated a transfer logo posted at foot of bed (two person pivot transfer without assistive device).

Review of resident's current plan of care indicated that resident #005 will continue to be toileted safely over the next three months; the care plan directs RA staff to toilet resident as needed with two staff to assist side by side, use mechanical lift as required. Further, the plan of care indicated that resident #005 will be safely transferred from one position to another over the next three months; the plan of care directs RA staff, under transfers, to provide two persons extensive physical assistance using sit/stand lift or two persons assist side by side, refer to Physiotherapist recommendation for safe transfer.

On April 5, 2016, interview with RA #104 indicated to the inspector that this morning resident #005 was found sitting at side of bed; RA #104 indicated that she/he transferred the resident to wheelchair and then and from wheelchair to toilet without a second person assisting in transfer and toileting; RA #104 indicated that she/he was unaware that the transfer status and transfer logo was changed to two person assist.

On April 6, 2014, interview with physiotherapist PT #124 indicated that resident #005's transfer status was changed last week from one to two person assist and that she/he verbally notified the floor nurse of the change.

On April 14, 2016, the DOC indicated that the expectation is that the care set out in the plan of care for resident #005 should be followed. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents #004 and #005 as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17. (1) (a), by not ensuring that the resident-staff communication system can be easily seen, accessed and used by residents, staff and visitors at all times.

Related to complaint Log#009066-16 for resident #005

Resident #005 was admitted to the home with multiple diagnosis including cognitive decline; resident #005 is at high risk of falling and has a tendency to self-transfer from bed and wheelchair.

On April 05, 2016, during an observation of resident #005's room, it was noted that the resident has no call bell attached to the staff-resident communication system to activate the system; it was noted that a bed sensor alarm was attached to the staff-resident communication system.

Interview with RA #104 indicated that the resident does not use the call bell because a bed alarm is in use and connected to the staff-resident communication system; whenever the resident tries to get out of bed, bed alarm will go off; RA #104 indicated no knowledge if resident is able to use a call bell. [s. 17. (1) (a)]

2. Related to Log # 003212-15 for resident #011

Review of clinical records for resident #011 indicates that the resident is at high risk of falling and the resident has a tendency to transfer self from bed and wheelchair.

Review of progress notes for resident #011 indicates that the resident had a recent fall on an identified date. The resident was found sitting down by the doorway of own room. The resident indicated falling while transferring from wheelchair to the bed and crawled to the door to call for help.

On April 11, 2016 at 1110 hours, inspector noted that the resident-staff communication system has no call bell attachment to activate system; It was noted that the attachment is used for bed alarm.

Review of current care plan for resident #011 directs staff under falls prevention interventions to keep call bell/personal articles within reach.

Interview with RPN #121 and RA #122 indicated that the resident will be able to use the call bell if available and connected.

On April 12, 2016, inspector noted that, next to bed in an identified, the staff-resident communication system is equipped with an adaptor to allow for both bed alarm attachment and call bell attachment to work together; this adapter was not utilized for resident #005 and resident #011.

On April 12, 2016 interview with DOC indicated that the staff-resident communication system is activated by using the call bell attachment unless the bed alarm is attached to the system; the bed alarm when activated it will alert staff if a resident is trying to get out of bed. The DOC confirmed to the inspector that staff-resident communication system will not be accessible to the resident or others if it is only attached to bed alarm and it will only be activated if the resident tries to get out of bed. [s. 17. (1) (a)]

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 ensuring that the resident-staff communication system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 51 (2) (b), by not ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Related to complaint Log#035785-15 and Log #007546-16 for resident #004

Resident #004 was admitted to the home with multiple diagnosis including cognitive decline.

Review of most recent MDS-RAPs indicated that resident #004 is incontinent of bowel and bladder, the resident wears a pad and also placed on a commode. Urinary incontinence improved this quarter related to resident's ability to tolerate sitting on the commode and void into toilet.

Review of current plan of care for resident #004 directs the following for toileting: check and change incontinent product 2 times per shift and as needed; has a toileting schedule:

0800; 1100; 1330; 1630; 1830; 2200 if awake. The toileting schedule is noted to be posted on the resident's washroom door.

Review of the Point of Care (POC) reports for resident #001 related to provision of continence care for six weeks period indicated that continence care was provided once per shift except for on the following shifts;
- seven days; continence care was provided twice on days shift.
- twelve days; continence care was provided twice on evenings shift.
- nine days; continence care provided twice on nights.

On April 8, 2016, interview with resident #004 indicated being toileted before breakfast and rarely toileted after breakfast / before lunch unless asking staff to be toileted. Resident #004 indicated waiting five to ten minutes because two persons are needed to assist with transfer and toileting. The resident indicated feeling uncomfortable when waiting thinking that staff forgotten about coming to assist. The resident indicated that sometimes when asking to go to bathroom, the nurse will tell the resident you have your diaper and the resident does not get changed until an hour later.

On April 8, 2016, inspector #570 observed resident #004 from 0930 hours to 1150 hours. During this period, resident #004 was not toileted or asked by staff if needed to be toileted.

Interview with RPN #121 confirmed to inspector that toileting schedule should be implemented as per plan of care and that she/he cannot speak to why resident #004 was not toileted as per toileting schedule around 1100 hours and that the primary RA #122 can answer that.

Interview with RA #122 indicated to the inspector that resident #004 was put on the toilet before breakfast but did not void. RA #122 confirmed that resident #004 was not toileted at 1100 hours as per toileting schedule and that she/he did not ask if the resident needed to be toileted knowing that the resident is wearing a brief.

Review of clinical records and interview with DOC indicated that a 5 Day Voiding Record and a 5 Day Bowel Record was initiated on an identified date in response to resident #004's concerns regarding the toileting schedule not happening. Interview with DOC indicated that once the 5 Day Voiding and Bowel records were completed a new toileting routine was implemented. Review of the 5 Day Records indicated that both had been partially completed and did not reflect the resident's toileting needs. The DOC confirmed

that the records should have been completed by the residents' assistants (RA) staff and followed by registered staff as required to create a new toileting routine that meets the needs of the resident.

Observations, resident and staff interviews indicated that the resident was not toileted as per toileting routine and that the 5 day Bowel and Voiding records were not completed as required to modify the toileting routine to meet the resident's needs; the Point of Care (POC) reports do not indicate that the resident was checked and changed twice per shift as per plan of care. [s. 51. (2) (b)]

2. Log #021238-15 related to resident #001

The licensee has failed to ensure that resident #001's individualized plan of care to promote and manage bowel and bladder continence based on the assessment was implemented.

The plan of care for resident #001 for a period of an identified date directs for toileting;
No potential to restore bladder continence
relating to: impaired mobility, cognitive
deficit
INTERVENTIONS:
Check and change incontinent product 2 times per shift and as needed

The plan of care for resident #001 for the subsequent period directs for toileting;
INTERVENTIONS:
Resident #001 is toileted 3 times daily as 0800 am; 1330 pm and 1800 pm and as needed.

Continence Assessment for resident #001 reviewed, for two consecutive quarters, by the inspector and no changes have been indicated on the assessments related to continence. The assessments direct;
The resident requires assistance with toileting, is incontinent of bladder and has no potential for bladder continence. Resident #001 is documented as being functionally incontinent, requiring toileting and wears a small brief.

Review of the POC reports for resident #001 related to provision of continence care for the period of three weeks of an identified month (when a new plan of care was initiated for toileting) directs;

The plan of care for resident #001 directs that the staff are to "check and change incontinent product twice per shift and as needed".
POC reports indicates that continence care was provided once per shift except for five shifts (two days shifts and three evenings shifts) on five identified dates of the one month period.

The plan of care for resident #001 after an identified date directs that the staff are to "toilet the resident three times daily 08:00 am, 13:30 pm and 18:00 pm and as needed." (Twice on day shift and once on evening shift)
POC report indicates that for the period of a one week period of an identified month, the resident is provided with continence care one per shift, but the times noted in the plan of care are not followed.
POC report indicates that for the following one month period, the resident is provided with continence care directs that;
- Only three days shifts during the period identified was the resident provided with continence care twice on day shifts as directed by the plan of care,
-Resident #001 was provided continence care once during the evening shift for the period identified but only provided care at 18:00 ten out of 31 shifts as directed in the plan of care.

Review of the POC report for continence for resident #001 directs that 11 out of 31 shifts the resident was not provided continence care for a period of 12 hours between care and numerous shifts identified where provision of care was not provided for period of 10-11 hours.

Interview with RA #117 was conducted on April 7, 2016 at 14:00 hours. RA #117 who works days, indicates to inspector that resident #001 was not a morning person and did not like to get up in the morning. Staff would approach the resident, but if the resident was not awake the resident was left in bed until ready to get up; sometimes it was 10:00 or 11:00 hours before the resident got up. RA #117 indicated to inspector that she/he would check resident while in bed, and change if the resident was wet, and would document in POC when product was changed.

RA #112 indicated that resident #001's daughter would come in to visit in the evening and would often toilet the resident after supper. Staff (RA's) would always toilet resident before the resident went to bed, RA #112 indicates that resident #001 could be resistive with toileting and would need reapproaching at time, resident #001 was very comfortable

and compliant with the daughter when visiting. (194) [s. 51. (2) (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 by ensuring that resident #004 and any other resident with individualized plan of care to promote and manage bowel and bladder continence is implemented, to be implemented voluntarily.

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.