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 soins 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
Feb 27, 2017	2017_484646_0001	012034-16, 014972-16, 016358-16, 017958-16, 018232-16, 018781-16, 032757-16, 032959-16, 035205-16	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

IVY LAM (646), TILDA HUI (512)

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): January 3, 4, 5, 9, 10, 11, 12, 13, and 16, 2017.

The following Complaint inspections were completed:
Log #012034-16 and # 013980-16 related to Residents' Bill of Rights, Plan of Care, Handling of Complaints, Administration of Drugs, and Falls Prevention and

Management,
Log #013155-16 related to Activation and Recreation,
Log #014972-16 related to Dignity, Choice and Privacy,
Log #016358-16 related to Nutrition Care and Hydration Programs,
Log #017958-16 related to Consent,
Log #018232-16 related to Plan of Care and Personal Support Services,
Log #018781-16, 019690-16, 020536-16, 032757-16, related to Plan of Care and Falls Prevention and Management,
Log #031210-16 related to Nursing and Personal Support Services, and
Log #032959-16 related to Housekeeping and Pest Control.

The following Critical Incident inspections were completed:
Log #020485-16, and #035304-16, related to Plan of Care and Falls Prevention and Management.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes, activation programs, housekeeping and environmental services, and meal delivery services, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Managers (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assistants (RA), Registered Dietitian (RD), Food Service Supervisor (FSS), General Dietary Staff (GDS), Continence Champion, Director of Environmental Services, Housekeeping Manager, Housekeeping Aides, Physiotherapist, Activation Programs Manager, Activation Assistant, Pet Therapy Volunteer, Social Worker, Intake Coordinator, Private Sitters, Family Council Chair, Residents' Council Chair, Substitute Decision-Maker (SDM), and Resident

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

This inspection is initiated related to activities for resident #001 for an identified recreational program and activities available for the resident.

Review of the Recreation Activity Database Recreation/Leisure Profile on an identified date revealed that the resident had identified recreation and leisure preferences for a specific activation program in the home. Review of resident #001's New Admission Checklist revealed that consent was provided by the resident's Substitute Decision-Maker (SDM) for the identified program. Review of the physician's note on an identified date, regarding the resident's identified behaviours and possible strategies revealed that the identified activation and recreation program had been advised. Review of resident's current written plan of care revealed that the interventions regarding the identified activation and recreation program was not included.

Review of the Activity Pro: Multi-Month Participation records between on an identified period revealed that the resident has participated in the identified activation and recreation program on an identified floor in the home for an identified number of times on a two identified months. After the resident was transferred to another identified home area, no further documentation of the identified activation and recreation program was recorded.

Interview with volunteer #108 revealed that he/she has brought the identified program to the floor on which resident #001 resides to visit residents, but he/she was not aware of resident #001's interest in the identified program. The volunteer further revealed that in addition to one-to-one visits with residents, the program was also available in the common area on an identified floor, where all the residents were welcomed to participate. Interviews with RA #104 and #106 revealed that they have seen the identified program in the home area in which resident #001 resides, and have not seen resident #001 participate in the program.

Interview with Resident Care Manager (RCM) #115 revealed that he/she was aware of resident #001's interest in the identified activation and recreation program and the staff an identified floor made effort to have for resident #001's participation in the identified program. RCM #115 further revealed that he/she was not aware if the resident continued to attend the identified activation and recreation program after the resident was transferred to the other home area.

Interview with Activation Assistant #114, who was in charge of activities in resident #001's current home area, revealed that he/she was aware of the resident's interest in the identified activation and recreation program. He/she further revealed that the resident did not attend the identified activation and recreation program in the current home area.

He/she revealed that it was his/her responsibility to update the resident's care plan and to follow-up regarding the resident's preference for the identified activation and recreation program, and he/she had not yet done so.

Interview with the Activations Program Manager revealed that resident #001 should have been on the list for the identified activation and recreation program. He/she confirmed that the activation staff's should have updated the resident's written plan of care to ensure that the resident's interest in the identified activation and recreation program was included when the resident was transferred to the new home area. The Activations Program Manager further confirmed that information regarding the resident's preference for the identified activation and recreation program was not included in the resident's written plan of care. [s. 6. (2)]

2. The licensee has failed to ensure that nursing staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The inspection was initiated related to complaints brought to the Ministry of Health and Long-Term Care (MOHLTC) of inconsistencies regarding continence care provided to resident #001.

Review of the resident's written plan of care on an identified date revealed that the resident was incontinent. Interventions set up to manage the resident's continence care needs included: referral to an incontinence product list for product usage and size, toilet as per schedule in Point of Care (POC), and as a toileting schedule that is posted in an identified resident area to provide toileting assistance for the resident identified times in the day and as required.

Interview with RA #101 described the resident as continent and used an identified incontinence product on days and second incontinence product on nights. Interview with RA #130 described the resident as incontinent and was using the first identified incontinence product on days and the second identified incontinence product on nights. Interview with RPN #119 indicated the resident was continent and was not using any incontinence products. Interview with RN #129 stated the resident was incontinent however he/she was not sure what incontinence products the resident was using. RN #129 indicated the plan of care should have included the type and size of the incontinence products the resident was using.

Interview with the DOC confirmed that there was a lack of collaboration among the nursing staff in the assessment of the continence care needs for the resident. [s. 6. (4) (a)]

3. The licensee shall 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.

Review of resident #001's current written plan of care revealed that the resident was at an identified nutritional risk level related to an identified health condition as a risk factor. A nutrition intervention was to avoid an identified food product. Review of the kardex on POC under Eating/Nutrition revealed that there was no information regarding not to provide the identified product to the resident.

Observations of resident #001 by the inspector at one meal revealed that the resident was provided an entrée with the identified food product that the resident was to avoid. Interview with general dietary staff (GDS) #102 confirmed that the resident was provided the identified food product that he/she was not to have. A subsequent interview with GDS #102 revealed that the information regarding not to provide the resident with the identified food product was listed on the Meal Plan sheet, but that he/she had overlooked it.

Interviews with RA #101 and #104 revealed that they were not aware that resident #001 had any food avoidances, and that the RD would communicate with the RAs if there were changes made to the resident's diet. The RAs further revealed that the information regarding not to provide the identified food product to the resident was not on the POC kardex, and they have not heard from the registered dietitian (RD) regarding not providing the identified food product to the resident.

Interview with RPN #103 revealed that he/she was not aware of any food avoidances that resident #001 had. Upon further review of the resident #001's plan of care, RPN #103 revealed that an intervention for the resident indicated not to provide the identified food product to the resident. RPN #103 further revealed that this information was not on the kardex, and that the RD changes the diet section on the care plan, but there was no 'K' beside the intervention to indicate that this information has been selected to go on the

POC kardex.

Interview with the RD revealed that information regarding residents' diets is on the meal planner sheet for the GDS, and for the RAs, the information would be on the kardex. The RD further revealed that it is the home's expectation for the dietary staff to be aware of residents' food avoidances, and the onus falls on the dietary staff as they have the dietary list to refer to but the RAs do not.

The RD confirmed that the GDS should have been aware of resident #001's intervention for not providing the identified food product to the resident, as the information was on the meal planner. The RD also confirmed that resident #001's intervention for not providing the identified food product to the resident should have been flagged on the kardex for the RAs. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

This inspection was initiated with regards to resident #001 being administered an identified medication despite the family having informed the home that the resident did not tolerate the medication well.

Interview with resident #001's SDM revealed one of the nursing staff on admission was informed by himself/herself that the resident should not be given the identified medication. The SDM expressed to the nursing staff that he/she preferred to be consulted with any other changes in the resident's medication.

Review of the resident's progress notes indicated an entry by RN #126 on an identified date at an identified time that a request was made by the SDM to RN #126 to hold off on giving the identified medication to the resident as the resident did not tolerate the medication well. There were no further documentation as to the follow up of this request. Review of the resident's medication administration record (MAR) for an identified month revealed the resident was prescribed the identified medication at an identified schedule as required. Resident was administered one dose of the identified medication on an identified date. The medication was noted to be discontinued on the MAR at a later identified date.

Interview with RPN #119 indicated information regarding any resident's response to medication would be recorded in a communication board and kept at the nursing station for the unit's attending physician to review at the next doctor's round. Interview with RN #126 stated he/she would have entered the above-mentioned information on the unit's communication board for the attending physician to review. The RN #126 could not recall how he/she may have communicated the information to the attending physician after she was informed by the SDM that the resident should not be given the identified medication.

Review of the unit's communication board did not reveal any written notification record to inform the attending physician of the above mentioned information.

Interview with RPN #119 confirmed the resident was not currently on the identified medication. Interview with the DOC confirmed that the resident's SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

5. The licensee has failed to ensure that the following are documented: The provision of the care set out in the plan of care.

The inspection was initiated related to multiple falls of resident #001.

Record review revealed that resident #001 had history of multiple falls since his/her admission. The resident was assessed at high risk of falls with multiple identified risk factors. Review of the resident's written plan of care on an identified date revealed multiple identified interventions developed to address the resident's risk of falls.

Review of resident's progress notes on falls revealed the resident had a fall incident on an identified date and time. The RPN on duty was called to the resident's room by housekeeping aide #131 at the time and noted the resident on the floor beside his/her bed. Housekeeping aide #131 reported to the RPN on duty that he/she found the resident on the floor minutes after the resident's care provider left the room. The housekeeping aide stated he/she heard the care provider on the phone with the resident's family prior to leaving the resident, and the resident was in bed at the time. The resident was assessed by the RPN on duty to have sustained no injury from the unwitnessed fall.

Review of the resident's documentation survey report for the identified date revealed that

hourly safety checks for the resident was not signed off on documentation system POC by the RA on duty for an identified shift and time.

Interview with housekeeping aide #131 recalled the incident and confirmed that the resident fell minutes after the resident's care provider left. Interviews with RA #130, RPNs #119 and 132, and RN #129 indicated hourly safety checks was to be conducted on the resident to ensure safety. The RA and RPN on duty on day of incident were not available for interview.

Interview with the DOC indicated that RAs were expected to document in POC after conducting hourly safety checks on the resident for the shift. The DOC confirmed that documentation was lacking to support that the safety checks had been provided to the resident. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

This inspection was initiated for resident #001 related to the resident's plan of care for shower schedule and method, and to the resident's activities attendance.

A review of resident #001's current written plan of care revealed that the resident attends an identified program for an identified number of days outside of the home, and the nursing staff is to prepare the resident to be picked up for the program. Review of the progress notes revealed that the last documentation regarding the resident's attendance of the day program had stopped after an identified date.

Interviews with Activation Assistant #114, and the Social Worker revealed that they were aware the resident used to attend an identified program, but were unsure if the resident still attended the program.

Interviews with RA #104 revealed that resident #001 used to attend a program outside of the home, but has stopped for a few months. Interviews with RPN #103 and #119 revealed that the resident used to go to the identified program, but no longer attends the program. RPN #119 further revealed that it was the nursing team's responsibility to update the written plan of care regarding the resident's attendance to the program, and that the written plan of care was not updated regarding program.

Interview with the DOC confirmed that the written plan of care should have been revised and updated when the care set out in the plan is no longer necessary. [s. 6. (10) (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:
1) the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
2) nursing staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
3) 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,
4) the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care,
5) the provision of the care set out in the plan of care is documented,
6) the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

This inspection was initiated related to multiple falls of resident #001. Record review revealed resident #001 was admitted on an identified date with multiple identified diagnoses. The resident was assessed to be at high risk for falls with history of falls, and other identified risk factors. Identified interventions were established.

Observations of resident #001 revealed the resident to attempt self-transfer. During the visit, the resident was observed to attempt to transfer from the bed.

Record review further revealed that the resident has had an identified number of falls since admission and sustained an identified number of injuries resulting from the identified falls. Review of the post-fall assessment tool in Point-Click-Care (PCC) revealed there were no post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls conducted on the resident for the five of the identified falls documented in the progress notes.

During interviews with RN #129, RPN #119 and #132, staff members indicated that since one of the falls prevention interventions was put in place, resident #001 has experienced reduced number of falls. The nurses indicated that they would try their best to conduct the post-fall assessment by using the appropriate tool on PCC after every fall. However, for the above-mentioned five falls that did not have the post-fall assessments, the assessments were not conducted after those falls.

Interview with the DOC confirmed that the post-fall assessments were not conducted for resident #001 for the above-mentioned five falls. [s. 49. (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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 7th day of March, 2017

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

Original report signed by the inspector.