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
Jun 16, 2017	2017_630589_0008	029660-16	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

JOANNE ZAHUR (589)

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): May 4, 5, 9, 10, 11, 12, 15, 16, 18, 19, 24, 25, 26, and 31, 2017.

Noncompliance under the LTCH Act, 2007, s. 19(1) and s. 24(1) identified in this inspection are being issued under concurrent Critical Incident Inspection #2017_420643_0008.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Care Manager (RCM), Employee and Labour Relations Manager (ELRP), Resident Assistants (RAs), Toronto Police Services, Volunteer Student, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, complaint and critical incident record logs, staff training records, staff personnel records and relevant policies and procedures.

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

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

- **4 WN(s)**
- **4 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of abuse of a resident by anyone is immediately investigated.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to incidents of witnessed abuse involving staff #133 towards resident's #010 and #011. The MOHLTC had also received a critical incident report related to incidents of witnessed abuse involving staff #133 towards resident's #010 and #011.

The home's investigation notes revealed that during interviews, staff #149 and #154 reported additional incidents of alleged abuse involving involving staff #133 towards resident's #024 and #025.

In an interview, staff #129 stated these additional incidents of abuse had been viewed as heresay and therefore had not been immediately investigated. [s. 23. (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 to ensure that every alleged incident of abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's substitute decision maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnesses incident of abuse or neglect of the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to incidents of witnessed abuse involving staff #133 towards resident's #010 and 011.

Review of progress notes for resident #010 revealed staff #134 had documented that several attempts made to notify resident #010's family member of the abuse had been unsuccessful. Further review of the progress notes failed to reveal that staff #134 had been successful in informing resident #010's family member about the abuse.

In an interview, resident #010's family member stated he/she had not been aware of any incidents of abuse until informed by the inspector which was more than nine months later.

In an interview, staff #134 acknowledged that resident #010's family member had not been notified within 12 hours upon the licensee becoming aware of witnessed abuse. [s. 97. (1) (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 the resident's substitute decision maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnesses incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to incidents of witnessed abuse involving staff #133 towards resident's #010 and 011. The MOHLTC had also received a critical incident report related to incidents of witnessed abuse involving staff #133 towards resident's #010 and #011.

In an interview, staff #136 stated he/she had observed incidents of abuse towards resident's #010 and #011 from staff #133. Staff #136 further stated he/she had sent an email letter to staff #134 reporting these incidents of abuse.

In an interview, staff #134 stated upon receipt of this email letter he/she informed staff #161. Staff #134 could not acknowledge if an analysis of the above mentioned incidents had been completed as he/she was relocated to another place of employment.

Review of the home's critical incidents binder did not reveal an analysis had been promptly completed.

In an interview, staff #161 acknowledged that an analysis of the above mentioned reported incidents of abuse had not been undertaken promptly after becoming aware of them. [s. 99. (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 to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff that provide direct care to residents receive training relating to abuse recognition and prevention based on the assessed training needs of the individual staff member as a condition of continuing to have contact with residents.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to incidents of witnessed abuse involving staff #133 towards resident's #010 and 011. The MOHLTC had also received a critical incident report related to incidents of witnessed abuse involving staff #133 towards resident's #010 and #011.

Review of the home's investigation notes related to the above mentioned incidents of abuse revealed during interviews with staff #149 and #154 additional incidents of alleged abuse involving staff #133 towards resident's #024 and #025.

Review of staff #133's personnel file did not reveal any additional training had been required for staff #133 to complete prior to resuming his/her duties.

In an interview, staff #162 stated the human resources (HR) department relies on the long term care (LTC) managers to determine whether a staff member requires further educational needs prior to resuming their duties and continuing to have contact with residents. Staff #162 further stated the HR department mainly assists the LTC managers with internal investigation interviews and determining disciplines.

Review of staff #133's education status report revealed Resident Abuse and Neglect and Resident's Bill of Rights by Surge learning had been last completed five months prior to

the witnessed staff to resident abuse.

In an interview, staff#133 stated he/she had been re-assigned to a new home area and had not been required to complete any additional training prior to continuing to have contact with residents after the allegations of witnessed abuse.

In an interview, staff #117 stated he/she was aware that staff #133 had been re-assigned due to communication concerns with residents however was not aware of the full extent of these concerns. Staff #117 further stated he/she was not aware of any additional education requirements or the development of a learning plan that staff #133 had to complete prior to continuing to have contact with residents.

In an interview, staff #161 acknowledged the additional incidents of alleged staff to resident abuse had been taken into consideration when deciding on the suspension discipline however any consideration to additional education specifically related to abuse recognition and prevention had not been considered prior to staff #133 continuing to have contact with residents. [s. 221. (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 all staff that provide direct care to residents receive training relating to abuse recognition and prevention based on the assessed training needs of the individual staff member as a condition of continuing to have contact with residents, to be implemented voluntarily.

Issued on this 21st day of June, 2017

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

Original report signed by the inspector.