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
Jun 15, 2017	2017_530673_0005	007018-17	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

BABITHA SHANMUGANANDAPALA (673)

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 and 15, 2017

The following complaint (Log #007018-17) was conducted related to privacy and personal support services.

During the course of the inspection, the inspector reviewed written correspondence from the home to the resident, the home's privacy breach report, and the resident's health records.

During the course of the inspection, the inspector(s) spoke with Family member, Clinical Instructor at Centennial College, Registered Practical Nurse (RPN), and Resident Care Manager (RCM).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services

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

- **1 WN(s)**
- **1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date. Review of the complaint revealed a privacy breach where a student nurse submitted an assignment with resident #003’s personal health information (PHI).

Documentation provided by the home to the inspector contained a letter from the home addressed to resident #003, and a Privacy Breach Report.

Review of the home’s Privacy Breach Report revealed that a clinical instructor (CI) at an identified nursing school discovered that a student had electronically submitted an assignment containing the PHI of a resident into the school's online system. Upon becoming aware of this, the instructor immediately reported the finding to the program coordinators at the identified school. The identified school was able to delete the file from the online system; however, the resident's PHI was on the system for approximately six to eight hours, during which time it was accessible to other CIs from the school.

Review of the letter from the home, addressed to resident #003 stated that the home had discovered a possible breach of his/her PHI on an identified date and were writing to notify him/her about the breach as required under Ontario’s Personal Health Information Protection Act (PHIPA).

In an interview, CI #169 from the identified school, who was also the supervisor of the student involved in the privacy breach, confirmed the details of the breach as noted above. CI #169 further confirmed that resident #003's right to have his/her PHI protected had been compromised.

Multiple attempts were made by the inspector to contact the student involved in the privacy breach; however, the student could not be contacted for an interview. [s. 3. (1) 11. iv.]

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 resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.