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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_626501_0017	027965-17	Complaint

Licensee/Titulaire de permis

Providence St. Joseph's and St. Michael's 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

SUSAN SEMEREDY (501)

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): October 5, 9, 10, 11, 12, 15, 16, 17 and 18, 2018.

The following intake was completed during this inspection:
Log #027965-17 related to falls prevention and management, infection prevention and control program, end of life care, pain and responsive behaviours.

This inspection was conducted concurrently with critical incident inspection 2018_626501_0018.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O.Reg 79/10 s. 49(2), identified in a concurrent inspection # 2018_626501_0018 (Log # 027772-17) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Manager (RCM), Clinical Informatics Specialist, physiotherapist (PT), registered dietitian, registered nurses (RNs), registered practical nurses (RPNs), resident assistants (RAs), private caregiver, and substitute decision-maker (SDM).

During the course of the inspection the inspector observed the delivery of resident care and services including infection prevention and control practices and staff to resident interactions. The inspector reviewed relevant policies and procedures and the resident's health records including medication administration records, documentation of the provision of care, email referrals and post fall assessments.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A complaint letter was sent to the home from resident #001's substitute decision-maker (SDM). The letter stated that resident #001 passed away after sustaining a specified injury.

Review of resident #001's medical record indicated the resident was admitted to the home with identified medical conditions. During an interview with DOC #105, they indicated resident #001 was identified to be at high risk for falls at an identified time period.

Review of resident #001's progress notes revealed the resident had 14 falls on identified dates. Post fall assessments were completed for 12 of the falls and 10 of these indicated that a referral was being made to the PT.

Review of PT progress notes indicated seven assessments were completed on identified dates. None of the PT assessments indicated whether the reason for the assessment was related to a referral due to a fall. However, during an interview with current PT #107, they indicated only two of these assessments appeared to be related to a recent fall. The home was unable to provide documentation that all post fall assessments included a referral via email to the physiotherapist. According to PT #107 and DOC #105

referrals are usually made through email or discussed at interdisciplinary meetings that occur Mondays, Wednesdays and Fridays. The home was also unable to provide documentation related to these meetings where resident #001's post falls may have been discussed.

Post falls assessments on three identified dates indicated poor nutrition/poor hydration was identified as a health status. Although the post fall assessment tool has "dietitian" as a possible referral, this box was not checked for these assessments. During an interview with RD #111, they stated they have never received a referral due to a post fall assessment. The RD indicated they were aware of resident #001's poor intake and also suggested that documented intake may not have been complete because of poor communication between care givers. The RD admitted they made no follow up related to this lack of clear documentation.

During an interview with DOC #105, they acknowledged the PT, RD and nursing department involved in resident #001's care failed to collaborate with each other in the post fall assessment of the resident. [s. 6. (4) (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 that staff and others 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, 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 :

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

A complaint letter was sent to the home from resident #001's substitute decision-maker (SDM). The letter stated that resident #001 passed away after sustaining a specified injury.

Review of resident #011's progress notes revealed the resident had 14 falls during their time in the home. Post fall assessments were completed for 12 of these falls.

Review of the home's policy #HP 045 titled Falls Prevention and Management (Falling Star Program) last reviewed/revised September 12, 2018, indicates registered staff are to complete a post falls assessment in their electronic documentation system to identify factors that may have caused the fall and add/change interventions appropriately. DOC #105 indicated to the inspector that the home initiated the post falls assessment in September of 2014.

During an interview with DOC #105, they acknowledged the home failed to complete a post falls assessment for resident #001 for falls that occurred on two identified dates. [s. 49. (2)]

2. The following evidence is related to resident #002 found under inspection report #2018_626501_0018:

The home submitted Critical Incident System (CIS) report # C554-000059-17 to the Ministry of Health and Long-Term Care on an identified date. According to the report, resident #002 had a fall on an identified date, was sent to the hospital and returned with

identified medical conditions. Review of resident #002's medical record indicated the resident had a gradual decline after the fall and passed away on an identified date.

Review of resident #002's progress notes revealed the resident had six previous falls on identified dates. Review of resident #002's assessments indicated there were no post falls assessments on four identified dates.

During an interview with DOC #105, they acknowledged that a post falls assessment would have been required for one of these falls that occurred on an identified date, according to their falls prevention and management policy. The other three falls occurred before their policy came into effect.[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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.