Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2019	2019_650565_0020	010964-19, 012762-19, 013904-19, 014525-19, 014674-19, 016147-19, 016759-19, 020345-19	Critical Incident System

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

MATTHEW CHIU (565), CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 23, 24, 28, 29, 30, 31, November 1, 4, 6, and 7, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intakes were inspected:
- #010964-19, #012762-19, #013904-19, #014674-19, #016759-19 related to falls prevention,
- #014525-19 related to prevention of abuse and neglect,
- #016147-19 related to safe storage of drugs, and
- #020345-19 related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Care Manager (RCM), Resident Care Supervisors (RCS), Social Worker (SW), Operations Leader Mechanical (OLM), General Maintenance (GM), Intake Coordinator (IC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assistants (RA), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. (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 resident #002's plan of care was revised at any other time when care set out in the plan had not been effective.

Review of the CIS report revealed that resident #002 had a fall on an identified date. The x-ray report revealed that resident #002 sustained a significant injury and was transferred to the hospital.

Review of resident #002's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment and the plan of care at the time of the above mentioned fall revealed the resident had both cognitive and physical impairments, and was at risk for falls. The plan stated the specified goals and interventions for falls prevention, and the falls prevention interventions were revised during an identified five-month period approximately 20 months ago.

Review of the progress notes and post-fall assessments revealed resident #002 had seven identified falls and injuries during the four-month period prior to the fall mentioned above.

Interviews with RAs #102, #103 and RPN #104 indicated that resident #002 had both cognitive and physical impairments, and they were at risk for falls due to the identified contributing factors. RAs #102 and #103 did not recall whether the falls prevention plan was changed during the above-mentioned four-month period. When reviewing resident #002's falls prevention plan with RPN #104, the RPN indicated that the interventions specified in the plan had not been revised since last year until after the last fall mentioned above. The RAs further stated the falls prevention plan might be able to reduce some of the falls but it was not effective to keep resident #002 from falling. RPN #104 stated based on the amount of falls that resident #002 had, the plan was not effective to prevent their falls.

Interview with the RCS #105 indicated that if the falls prevention care had not been effective, staff should bring it to the falls prevention rounds and/or the team to develop and implement new interventions for preventing the falls. RCS #105 acknowledged that during the period of the above-mentioned falls, resident #002's falls prevention plan of care had not been effective and it was not revised as required. [s. 6. (10) (c)]

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 the resident's plan of care is revised at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to resident #008, for which resident #008 was taken to a hospital and that resulted in a significant change in the resident's health condition.

This inspection was initiated to inspect intake log #020345-19.

Review of the CIS report identified that on an identified date, resident #008 incurred an injury which required hospitalization and resulted in a significant change to the resident's health status.

Review of resident #008's clinical records, and interviews conducted with the resident and staff confirm the identified date as the date that the injury and hospitalization occurred.

The CIS report was submitted 18 days later.

Interview with RCS #105, who initiated the report confirmed that the report was not submitted on time. [s. 107. (3) 4.]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.