Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Feb 28, 2020	2020_804600_0003	020361-19, 020964-19, 021878-19, 021909-19, 023456-19, 023554-19, 023575-19, 024273-19, 000916-20	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

GORDANA KRSTEVSKA (600), DEREGE GEDA (645), ORALDEEN BROWN (698)

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): February 3, 4, 5, 6, 7, 10,11, 2020.

During this inspection the following intakes had been inspected:
#020361-19, related to abuse,
#021878-19, #023575-19, #000916-20, #020964-19, #023554-19, related to falls,
#021909-19, #024273-19, related to responsive behaviour,
#023456-19, related to personal support services.

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 (RCSs), Registered Nurse in Charge (RNC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Behaviour Support of Ontario (BSO) lead, Resident Assistants (RAs), Personal Caregiver (PC), Resident Care Supervisors (RCS), and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, resident and staff interactions, the provision of residents' care, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was sent to the Ministry of Long Term Care (MLTC) regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and resident’s health record indicated that on a specified date resident #006 was found on the floor after the resident was brought back from the dining room and left in their room.

A review of the resident's MDS records indicated that the resident had significant changes in their condition since the previous quarterly assessment, when the resident had history of falls with an injury and they needed extensive assistance by two staff for a specified activity of daily living.

A review of the resident’s written plan of care dated prior the fall indicated that the resident had been identified at risk for fall. The goal set was the resident to remain safe and to have no falls over the next three months. Further review of the resident’s plan of care, under the specified activity section, indicated that the resident needed two persons extensive to total physical assistance for safety using an assistive device. The plan of care for the specified activity did not indicate when the resident was to be assisted, or if the resident would ask for assistance or the staff was to offer and assist the resident.

A review of the resident's health history records in progress notes indicated that prior to the fall on the identified date, the resident was independent in identified activities of daily living. On three separate dates resident #006 had a fall when they tried to assist self with a specified activity of daily living. On the last fall the resident sustained an injury.

An interview with resident assistant RA #102 indicated that they were aware that the resident was at risk for falls as they tried to assist them self, and they had a plan in place. As per the RA, the resident was able to call when they need assistance so whenever they called they would go to assist them. An interview with RA #118, indicated that they were aware of the resident's risk for fall and they assist the resident when the resident requires, but usually after lunch. In an interview, the Registered Practical Nurse (RPN) #100 indicated that they were aware of the resident's risk of falls and they have a plan in place but they are not sure if resident #006 was able to ask for assistance when they need, or the staff to provide care to the resident as per the plan, as the plan of care did not indicate that.

In an interview with Resident Care Supervisor (RCS) #124 they indicated that the direct care staff are to know and follow the resident's plan of care and report if there are changes in the residents' condition and change in their needs. Registered staff are to document those changes, resident needs and direct the staff what interventions to be provided. The RCS acknowledged that the staff knew the plan of care for resident #006, and that the resident had three falls when they tried to perform the activity of daily living on their own,however, they interpret the plan differently as the plan did not give clear direction to the staff, about when to provide care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted to the MLTC regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and resident's health record indicated that on a specified date RA #123 observed resident #004 to have a skin alteration that was later identified by an x-ray assessment as an injury to resident #004's body part.

A review of the resident's MDS quarterly summary on a specified date, indicated that the

resident had moderate cognitive impairment. A physiotherapist (PT)'s assessment indicated that the resident needed extensive assistance by one staff for identified activities using an assistive device.

A review of the resident's health report indicated that on an identified date, the resident had an unwitnessed fall, but no injury was identified at that time. On another identified date the resident had a skin alteration that a few days later was confirmed by an x-ray as an injury. The resident had been ambulating self with the assistive device around both units and the staff was not able to identify how the resident sustained the injury. The resident also had responsive behaviour as they were ambulating self in another area and other resident's rooms. An identified behaviour that the resident had exhibited was not easily altered when the staff tried to redirect the resident so the BSO team recommended DOS monitoring. On an identified date the resident was accommodated with one to one staff to monitor and distract the resident prior to them approaching another resident and to provide care and safe environment for the resident.

A review of the resident's plan of care prior the incident indicated that the resident needed one to two staff to provide extensive assistance for an identified activity of daily living. Resident used an assistive device as mode of locomotion and the staff was to supervise and monitor the resident for safety.

A review of the RA's "Daily documentation Record" for an identified month, indicated that on two days, the resident had received total assistance by one staff for an identified activity of daily living. Further the record indicated that the resident had been receiving extensive and total assistance by one staff in the period prior the incident for all activities of daily living.

A review of the resident's health record for the period prior the incident, indicated that the resident had not been observed for an identified period prior the incident. Review of the progress notes indicated that on a specified date there was no one to one assistance for resident #004.

An interview with RA #118, indicated that they were resident #004's primary caregiver but because the resident had exhibited an identified behaviour the resident was on one to one DOS monitoring for an identified period. Further the RA stated that on the specified date the resident did not have one to one staff for assistance, so RA #118 left the resident in bed. The RA also stated that on the identified date they provided assistance to the resident by themself. The RA was aware that the resident's plan of care

directed the staff to use two staff assistance, but the RA also stated, because the resident did not have one to one, and the resident did not exhibit responsive behaviour, they provided care to resident #004 alone.

An interview with RA #119 indicated that they provided care to the resident as assigned primary caregiver and also as one to one staff assistance for DOS monitoring. Further the RA stated that they provided care to the resident alone as the resident is able to assist in care.

In an interview with RA who was working one to one DOS monitoring for resident #004 and who identified the large skin alteration on the resident, indicated that they had been assigned to resident #004 a few times and they knew the resident and knew the resident was at risk for fall, so they had provided care to the resident with another RA, who usually would be the primary caregiver.

In an interview, the RCS #124 confirmed that all the staff is expected to follow the direction of the plan of care and to notify the nurse in charge if there is a change in the resident’s condition that may require increased or decreased level of care. The RCS acknowledged that resident #004 was not provided care by RA #118 as indicated in the plan of care for the period prior to the incident. [s. 6. (7)]

3. Record review of a CIS report, submitted to the MLTC indicated that resident #003 had a fall and sustained an injury.

Record review of the progress notes indicated that resident #003 had an unwitnessed fall in their room. The home completed a post fall assessment and developed interventions to prevent further falls.

On an identified date resident #003 was observed in their bed and an identified device was not applied. An interview with personal caregiver (PCG) #115 confirmed that the device was not in place. The PCG indicated that they stopped applying the device a week ago because the resident gets agitated. An interview with the primary RA #116 indicated they don’t always apply the device so as not to agitate the resident.

An interview with the PT revealed that they developed the interventions collaboratively with the registered staff and placing a device was one of them. The PT indicated that they were not sure why the device was not applied, and they expect the RAs and PCAs to apply the device when the resident is in bed.

An interview with the DRC confirmed that the plan of care for resident #003, directed staff members to apply a device to prevent further falls. They reiterated that staff members are expected to provide care as specified in the plan of care and confirmed that the resident did not receive care as specified in the plan. [s. 6. (7)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident,
- to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Record review of a CIS report submitted to the MLTC indicated that resident #003 had a fall and sustained an injury.

Record review of the post fall assessment completed by the PT indicated that the resident required a two-person physical assist for identified activities of daily living.

Inspector #645 observed PCG #115 providing assistance to the resident with no other staff assistance. The next day, PCG #114 was also observed providing assistance to the resident with no other staff assistance.

Separate interviews with PCGs #114 and #115, confirmed that they usually assist the

resident alone. Both PCGs indicated that they have access to the plan of care and they were aware that the resident was a two person assistance for the identified activities of daily living. PCG #115 indicated that they were assigned to the resident on a full-time basis and assisted them with personal care. They indicated that the resident can be assisted by one person if they don't exhibit responsive behaviours and on the identified date the resident was cooperative hence completed the care alone. PCG #114 indicated that they mostly seek assistance from the primary RAs but on the following identified date they did not seek assistance because the RA was not available so they completed the task alone. Interview with the primary RA #116 indicated that the two PCGs were not supposed to do the transfers alone as the resident required two-person assistance. The RA further indicated that the PCGs are not allowed to provide care unless the RAs are in the room observing. For all types of care, PCGs are expected to call the primary RAs prior to commencing care. The RA indicated that resident #003 is at high risk for fall and conducting a one-person assistance was unsafe.

Interview with the PT indicated that the resident sustained injury of an identified body part and required treatment. In such situations, two-person assistance is very important to prevent an injury. The PT indicated that resident #003 is at high risk for fall and providing one-person assistance was unsafe and jeopardizes the resident's well-being.

Interview with RCM #113 indicated that the two PCGs were not supposed to do the transfers alone as the resident required two-person assistance. Conducting a one-person transfer is unsafe and poses risk to the resident. The RCM further indicated that the two PCGs are not to provide care to the resident unless they are supervised by the primary RAs. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident experiencing responsive behaviors, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

Record review of a CIS report submitted to the MLTC showed that resident #002 had an incident with injury which required transfer to hospital. Resident #002 experienced responsive behaviors, fell and sustained an injury.

Record review of the care plan indicated that resident #002 experienced history responsive behaviour and the plan of care guided the staff to use two staff assistance to perform care due to resident #002's responsive behaviors.

A review of the progress notes indicated that resident #002 was very restless, while sitting on an assistive equipment in their bedroom after being assisted with care. The equipment tipped over and resident fell on the floor, sustaining an injury. Two skin alteration were also noted, so the resident was sent for further investigation. Resident was sent back to the home with treatment. Results of the investigation showed no further injury.

Record review of the resident #002's clinical record indicated that resident #002 was previously followed up by an identified team and was discharged from the program.

A review of the home's "Responsive Behavior Policy" #HP053 dated July 2010, with

revision date September 2019, indicated that responsive incidents will be monitored and reported as part of the strategic direction to prevent harmful incidents to residents and staff; external resources will be accessed if responsive behaviors cannot be managed; use internal and external tools, experts and resources for screening, assessing and developing strategies for managing responsive behaviors; if interventions are ineffective, referral can be made to the Psychiatric Resource Consultant (PRC) and/or the Psychogeriatric Outreach Program (POP), the Behavior Support Outreach Team (BSOT). A transfer to acute care/geriatric rehab/behavior unit may be required.

An interview with RA #109 indicated that resident #002 was very calm and cooperative during their care with two staff assistance just before bed on the identified date. RA #109 stated that when they came back to resident #002's room, the resident started behaving. RA #109 stated that they were standing aside, when the resident made a sudden movement to the right and the equipment tipped over, causing the resident to fall and sustain an injury. RA #109 also stated that the Registered Practical Nurse (RPN) was paged and attended to the resident immediately after which the resident was sent for further investigation.

An interview with RPN #110 indicated that on the identified date, resident #002 received scheduled medication prior to the assistance with care. Further, the RPN stated that they were paged to resident #002’s room by RA #109 due to a fall and when they went to the room, resident #002 was lying on their side with noted injury and equipment behind the resident. RPN #110 also stated that they contacted the doctor who ordered the resident to be sent for further assessment. RPN #110 acknowledged that resident # 002’s responsive behavior was the cause of their fall, however, they did not refer the resident to BSO team for reassessment. RPN #110 stated that at the time of the incident, they did not consider contacting BSO for support nevertheless they would need to ask the doctor to refer the resident to BSO team as they cannot refer any residents themselves.

An interview with BSO lead #103 indicated that they were not familiar with resident #002 nor aware that resident #002’s fall was a result of responsive behaviors. BSO #103 stated that there is a process for behaviors and mental health consult and that staff are expected to send an email to the BSO clinic as well as notify the doctor when a referral is needed. BSO #103 also stated that staff are encouraged to use non-pharmacological approaches first, then pharmacological and when those approaches are ineffective, a consult is required from the BSO who comes in and assess the resident.

An interview with the Director of Resident Care (DRC) #117 stated that their staff rounds

are done three times per week with the interdisciplinary team and that resident #002's incident was identified as a fall due to a responsive behavior. Further the DRC stated that the home has a process in place regarding responsive behavior program management and the staff have direct access to the BSO team without a doctor's referral for assistance in managing residents with responsive behavior. [s. 53. (4) (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 for each resident experiencing responsive behaviors, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system, was complied with.

In accordance with LTCHA, c. 8, and O.Reg. s. 30 (1). the licensee was required to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents and there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols. Specifically staff did not comply with the licensee's policy titled Private Care Givers, HP350, last revised on May 2019, that defined Private Care Givers, and directed staff members and the home's management team to do the following: A Private Duty Care Givers is hired directly by the resident/family member. The registered staff and RAs will remain responsible for monitoring and evaluating overall resident care. The home does not allow private care givers to provide nursing care without staff oversight.

During the inspection, Inspector #645 observed care provision for resident #003 by PCG #115 who assisted resident #003 from their bed to an assistive device with no other staff assistance. Similarly, on the next day, PCG #114 was observed assisting the resident during an identified activity of daily living with no other staff assistance. On both occasions, no staff members were observing the care.

Separate interviews with PCG #114 and #115, indicated that they usually provide care for the resident alone. They indicated that PCGs are not allowed to provide care without staff oversight, however, they know the resident very well and staff members are not always available. PCG #114 indicated that they mostly seek assistance from the primary RAs but on the day of the observation, they did not seek assistance because the RA was not available and completed the transfer alone. Interview with the primary RA #116 indicated that the PCGs are not allowed to provide care unless the RAs are in the room observing.

An interview with the DRC indicated that PCGs are not to provide care to residents without staff oversight. The policy of the home states that, for all types of care, PCGs are expected to call staff or the primary RAs prior to commencing care. The DRC further indicated that they will remind PCGs not to perform any type of care without staff presence. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s zero tolerance of abuse and neglect policy, was complied with.

A CIS report was received by MLTC regarding an alleged incident of financial abuse. The report indicated that resident #007 notified their family friend that RA #112 took an identified from them. The family friend reported the alleged incident to the home's management team and the home reported the incident to the MLTC.

The home's policy titled " Zero tolerance of Abuse and Neglect and Mandatory Reporting #HP107", last revised in March 2019, directed staff members to do the following: staff members at the home should immediately report any alleged, suspected or witnessed incident of abuse to the immediate supervisor.

Record review of the home's investigation note indicated that RA #112 stated that the resident was upset and told the RA that the POA took the item away from them a few weeks ago.

An interview with RA #112 confirmed that they did not report the alleged incident of abuse to the supervisor. The RA indicated that it was a learning curve for them and in future, they would report any alleged/witnessed incident of abuse is reported to the supervisor.

An interview with the RCM #113 confirmed that the RA was disciplined for not reporting the incident of abuse to them. The RCM indicated that the home’s internal incident reporting policy on zero tolerance of abuse and neglect, directed staff members to report any alleged, suspected or witnessed incident of abuse to the immediate supervisor. [s. 20. (1)]

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.