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
Mar 10, 2022	2022_631210_0005	007899-21, 011571-21, 012658-21	Critical Incident System

Licensee/Titulaire de permis

Unity Health Toronto
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

SLAVICA VUCKO (210)

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 22, 23, 24, 25, 28, March 1, 2, and 3, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
-intake #012658-21 related to Personal Support Services (PSS);
-intake #011571-21 and #007889-21 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Operational Leads (OL), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Aids (RAs), Behavioral Support Ontario (BSO) Lead, Physiotherapist (PT), Infection Prevention and Control (IPAC) Lead, residents and family members.

During the course of the inspection, the inspectors conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and relevant policies and procedures.

A mandatory Infection Prevention and Control (IPAC) check list was completed.

Inspector Reji Sivamangalam #691958 attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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	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. (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).

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).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other.

Resident #001 had a fall and was transferred to the hospital. The fall resulted in an injury with no change in the resident's Activities of Daily Living (ADL).

RN #104 indicated that resident #001 frequently performed a specific self-care without calling for staff assistance. This behavior placed the resident at risk for falls. BSO Lead #106 indicated that the resident should have been referred to them for further assessment of the behaviour. The BSO Lead #106 was not aware of resident #001's behaviour as they had not received a referral to assess resident #001's behaviour.

RPN #104 indicated that after each fall a referral was sent to the Physiotherapist for post fall assessments. Referrals were sent after each fall in the last six months and no post fall Physiotherapy assessments were completed. The Physiotherapist was a member of

the Post Fall Committee.

Resident #001 was not assessed by the PT and BSO Lead #106, to mitigate their risk for falls.

Sources: CIS, resident #001's care plan and clinical records, home's investigation notes, observations and interviews with staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

Resident #001 was at risk of falls. There were specific interventions in the care plan for falls prevention.

During observations by the inspector, it was noted that the specific falls prevention interventions were not in place.

Staff were unaware of the above mentioned fall prevention interventions for resident #001.

Resident #001 was not provided with a specific fall prevention interventions as per the written plan of care which placed them at increased risk for falls.

Sources: CIS, resident #001's care plan and clinical records, observations and interviews with staff. [s. 6. (7)]

3. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On a specified date resident #001 sustained a fall.

Resident #001 required one person limited physical assistance in a specific personal care activity. The resident was known to attempt performing selfcare, and staff were to discourage this behaviour for safety.

RA #101 indicated that resident #001 was able to perform self-care for the above mentioned personal care activity and they were not assisting the resident. RPN #102 did

not assess if the resident was able to perform the specific task without assistance.

Resident #001 was not reassessed when their needs changed related to specific personal care they required. As a result the resident was at risk for poor hygiene and increased risk of falls.

Sources: CIS, resident #001's care plan and clinical records, home's investigation notes, observations and interviews with staff. [s. 6. (10) (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 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, the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 5th day of April, 2022

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

Original report signed by the inspector.