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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 17, 2017	2016_503649_0024	021774-16	Complaint

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET NORTH YORK ON M2K 1E1

Long-Term Care Home/Foyer de soins de longue durée

SENIORS' HEALTH CENTRE
2 BUCHAN COURT NORTH YORK ON M2J 5A3

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

JULIEANN HING (649)

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): July 22, 25, 26, 27, 28, and October 5, 6, and 7, 2016.

This inspection was conducted concurrently during the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Associate Directors of Care (ADOC), Pharmacist, Social Worker (SW) Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aids (HCAs), Personal Support Workers (PSWs), Environmental Service Supervisor, residents and family members.

During the course of the inspection, inspector observed staff to residents interactions, conducted interviews, reviewed relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Under O. Reg. 79/10, s.5 for the purpose of the definition of "neglect" in subsection 5 of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date in July 2016, a complaint was submitted to the Ministry of Health and Long-term Care (MOHLTC) related to an identified resident who was unable to sleep at night as his/her roommate engaged in a loud activity and behaviour all day and night, seven days per week.

In an interview the identified resident told the inspector that he/she had not slept the first three nights and was unable to live a normal life since admission. The identified resident revealed that he/she felt hopeless and felt his/her rights had not been respected. The identified resident further stated that he/she was unable to wear ear plugs provided for personal reasons.

Interview with identified resident's Substitute Decision Maker (SDM) revealed that co-resident engaged in a loud activity “all hours of the day” and identified resident had been unable to sleep resulting in a fall on a specified date in July 2016, in the washroom. A review of the home’s progress notes revealed that the resident had slipped on his/her urine and fell and had not sustained any injury.

During an interview RN #150 revealed that the co-resident had not been compliant with modifying the activity and behaviour. In an interview PSW #207 revealed that the co-resident would engage in the activity at 0400 hours. In interviews with RN #207 and PSW #105 revealed that co-resident engaged in the activity less when the identified resident was not there.

A record review of the identified resident’s progress notes revealed that there had been daily reports about the loud activity to the nursing staff within the home as follows:

- On an identified date in July family visited this evening voiced complain of roommate's loud activity
- On an identified date in July complains of roommates' loud activity and behaviour
- On an identified date in July continue to complain about roommate’s activity. An intervention was offered to resident #085 but refused

- On an identified date in July refused dinner agitated by roommate's loud activity
- On an identified date in July resident is given an intervention at bed time to block out the activity resident refused
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On an identified date in July 2016, the family removed the identified resident from the home as they felt resident was being emotionally abused by his/her roommate as demonstrated by the failure to modify the activity and behaviour.

In interviews RN #207, ADOC #159 and #105 revealed that there were no interventions or monitoring implemented for either of the residents. The staff failed to provide the identified resident with the service or assistance required for his/her well-being and included a pattern of inaction that jeopardized the resident's well-being when interventions were not implemented despite the resident's complaints. [s. 19. (1)]

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 home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.