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
Oct 4, 2016	2016_393606_0011	033172-15, 005379-16	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

JANET GROUX (606)

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 25, 26, 27, 28, 2016.

This complaint was inspected concurrently with the home's Resident Quality Inspection Inspection #2016_413500_0009 log #019595-16. The following intakes were inspected concurrently during this inspection: Critical Incidents related to staff to resident abuse log #005379-16, and #033172-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinator (RAI), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Services (PSWs), Environmental Services Manager (ESM), Environmental Technician, Activation Coordinator (AC), Registered Respiratory Therapist (RRT) Private Duty Nurse (PDN), Corporate Risk Manager (CRM) at Patient Experience and Quality Personnel (NYGH), and SDM (Substitute Decision Maker).

During the course of the inspection, the inspector conducted observations of residents and home areas, conducted staff interviews, reviewed clinical health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the

complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A complaint was received by the Ministry on an identified date, concerning missing valuables belonging to resident #033. According to the complaint the home did not investigate or respond to the complaint in an appropriate manner.

Review of resident #033's clinical records on an identified date revealed resident #033 informed the staff his/her valuables were missing and the SDM had been in to search resident #033's room and was unable to find the missing valuables. Further documentation revealed a concern form was completed and forwarded to the ADOC.

Review of communication on four identified dates between the home and SDM via emails revealed the following:
-indicated the SDM requested information about the investigation and requested a copy of the incident report regarding the missing valuables.
-SDM requested a formal reply from the home regarding the missing valuables.
-the home responded and provided the SDM to contact the CRM at North York General Hospital (NYGH) to follow up regarding the missing valuables.
- SDM informed the home he/she had contacted the CRM at Patient Experience and Quality and he/she indicated he/she was not able to get any information about the missing valuables. He/she again requested information from the home about the investigation and incident report.

Review of an identified home's policy states:
-any complaint (verbal, written, telephone, or e-mail) received at the home or head office from residents, families, visitors, and staff shall be investigated and actions shall be taken for resolution.
-written complaints
Follow these steps:
contact the complainant to obtain the information about the areas of concern.
conduct and document an internal investigation
prepare a written response to summarize the issue and actions agreed to in any meetings held with the complainant. Ensure that documentation includes:
the nature of the written complaint
the date the complaint was received
the type of action taken to resolve the complaint, including date of action, timeframes for actions, and any follow up action required the final resolutions

every date on which any response was provided to the complainant and description of the response.
any response made by complainant
provide a written response to the complainant within 10 business days of receipt.

Interview with the SDM revealed the home did not initiate a follow up to his/her concerns that he/she reported to the home on two identified dates until he/she inquired about it in an email 22 days later. He/she further revealed the missing valuables were many years old and were gifts from resident #033's relatives and held sentimental and emotional values that cannot be replaced. He/she stated the home was not able to find resident #033's missing valuables.

Interview with RPN #135 revealed he/she was the charge nurse the day the SDM reported the missing valuables to him/her. The RPN indicated he/she completed the home's incident report regarding the complaint and forwarded it to the ADOC.

The RAI Coordinator/ADOC told the inspector that the incident report was missing.

Interview with the RAI Coordinator/ADOC and the Administrator confirmed although there was a follow up to the complainant's concerns, it was not commenced immediately as stated in their policy. [s. 101. (1) 1.]

2. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

A complaint was received by the Ministry on an identified date concerning missing valuables belonging to resident #033. According to the complaint the home did not investigate or respond to the complaint in an appropriate manner.

Review of an identified home's policy states:
any complaint (verbal, written, telephone, or e-mail) received at the home or head office from residents, families, visitors, and staff shall be investigated and actions shall be taken for resolution, and provide a written response to the complainant within ten business days of receipt.

Interview with the SDM revealed the home did not provide him/her the outcome of their investigation regarding his complaint.

Interview with the RAI Coordinator/ADOC and the Administrator confirmed the home did not provide a response to the complainant regarding the outcome of their investigation They confirmed resident #033's missing valuables was not found. [s. 101. (1) 3.]

3. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

A complaint was received by the Ministry on an identified date, concerning missing valuables belonging to resident #033. According to the complaint the home did not investigate or respond to the complaint in an appropriate manner.

Review of the home's investigation documentation was not available.

Interview with the DOC and ESM revealed the home's practice is to investigate any concerns received and records of the investigation are kept.

Interview with the RAI Coordinator/ADOC and Administrator confirmed they were not able to locate the investigation documents required to be kept. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

Issued on this 8th day of November, 2016

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

Original report signed by the inspector.