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 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

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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
Jan 15, 2019	2018_626501_0023	029535-18	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

SUSAN SEMEREDY (501)

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): December 6, 7, 10, 11, 12, 14, 17, 18, 19, 20, 21, 27, 28, 2018, and January 2, 2019.

The following intake was completed during this inspection:
Intake #029535-18 related to the prevention of abuse and continence care and bowel management.

Written Notification and Compliance Order, related to S.O. 2007 c.8 s. 19 (1), identified in this Complaint Inspection #2018_626501_0023 has been issued in concurrent Critical Incident Inspection #2018_626501_0022.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOC), registered staff (RN, RPN), registered dietitian (RD), personal support workers (PSW), Manager of Labour and Employee Relations, physiotherapist, residents, family members, and substitute decision-makers (SDM).

During the course of this inspection the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan that includes the type and level of assistance required relating to activities of daily living was developed for each resident.

Review of a complaint letter addressed to the home and the Ministry of Health and Long-Term Care (MOHLTC), indicated resident #015's substitute decision-maker (SDM) had concerns regarding the care resident #015 was receiving.

According to the letter, resident #015 was admitted to the home following an identified medical procedure and was to be non-weight bearing for identified extremities until assessed by the physician.

Review of the plan of care for resident #015 that had been initiated the day of admission stated the resident required two person physical assist for transfers. Review of progress notes indicated that a few days later, resident #015's SDM approached registered staff and stated that the resident had pain and claimed that during an identified ADL, the resident was asked to use their extremities. Review of the plan of care for the identified ADL indicated that interventions for this ADL was not initiated until several days after admission.

During an interview with DOC #116, they stated they were aware that this plan of care for resident #015 had not been completed within 24 hours of admission that included the type and level of assistance related to the above identified ADL. [s. 24. (2) 3.]

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 a 24-hour admission care plan that includes the type and level of assistance required relating to activities of daily living is developed for each resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (3) A licensee who reports under subsection (2) shall do so as is provided for in the regulations, and include all material that is provided for in the regulations. 2007, c. 8, s. 23 (3)

Findings/Faits saillants :

1. The licensee who reported under the LTCH Act, 2007, c.8, section 23. (2) failed to do so as is provided for in the regulations, and include all material that is provided for in the regulations.

According to the LTCHA, 2007, c.8, section 23(2), the licensee shall report to the Director the results of every investigation undertaken under clause (1)(a) and every action taken under clause (1) (b).

Review of communication provided to the inspector indicated the home forwarded a complaint letter to the MOHLTC via email on an identified date. The letter was from resident #015's SDM alleging abuse and improper care. A follow up email indicated the home had completed their investigation and concluded that the PSW in question would no longer provide service to the identified resident. The writer indicated the SDM was updated and human resources action was taken regarding the PSW.

The above communication to the MOHLTC failed to include
• the type of incident,
• a description of the individuals involved in the incident including the names of any staff members or other persons who were present at or discovered the incident,
• whether a physician or registered nurse in the extended class was contacted,
• what other authorities were contacted about the incident, if any,
• the outcome or current status of the individual who were involved in the incident, and
• an analysis including the long-term actions planned to correct the situation and prevent recurrence.

During an interview with Administrator #132, they acknowledged they were unaware they should have reported the above mentioned letter as a critical incident system (CIS) report as they thought they just needed to forward the letter as a written complaint. During an interview with DOC #116, they confirmed a CIS report should have been submitted as well as the complaint letter. [s. 23. (3)]

Issued on this 25th day of January, 2019

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

Original report signed by the inspector.