Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jun 20, 2019	2019_751649_0011	013308-18	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

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): June 3, 4, 5, 6, 7, and 11, 2019.

The following intake was completed in this complaint inspection:
Log #013308-18 was related to Residents' Bill of Rights, housekeeping, dress, dining and snack service, pain management, continence and bowel management, maintenance services, nursing and personal support services, and prevention of abuse and neglect.

PLEASE NOTE: A Written Notification and a Voluntary Plan of Correction related to LTCHA, 2007, c.8, s.6. (7) was identified in this inspection and has been issued in Inspection Report #2019_751649_0012, dated June 20, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with assistant directors of care (ADOCs), nurse practitioner (NP), registered nurses (RNs), registered dietitian (RD), registered practical nurse (RPN), complainant, and residents.

The inspector conducted observations of staff to resident interactions, conducted observations of residents, reviewed residents' health records, investigation notes, staffing schedules, and reviewed relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Sufficient Staffing

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #010 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint alleging concerns related to resident #010's identified medical condition.

Resident #010 no longer resided in the home at the time of the inspection.

A review of progress notes indicated documentation of resident #010 reporting pain on identified dates and pain medication was administered however, there was no documentation to indicate that the physician or NP had been informed of the resident's repeated complaints of pain. The resident was seen by the physician on a later date during rounds with the RN, documentation was completed by the physician related to another medical issue however, there was no mention of the resident's reported pain.

Further review of progress notes indicated that the resident continued to complain of pain on later dates. A visiting physician was asked to assess resident #010 regarding their pain and ordered a specified diet type. No additional orders were received at this time. On a later date the resident continued to complain of pain, an assessment was completed, the physician was contacted, and the resident transferred to hospital.

A review of the physician and the NP progress notes after resident #010 returned from emergency room (ER) indicated documentation of an identified medical condition.

In an interview with NP #109, they indicated when they first became involved in the resident's care related to another medical condition and the next time was at a later date when they became aware of the resident's identified medical condition. Given that the NP had no knowledge of the resident's pain and the physician was not notified of the pain during their visit with the resident, indicated there was no collaboration with the registered nursing staff in the assessment of resident #010 so that their assessments were integrated and were consistent with and complement each other. [s. 6. (4) (a)]

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 of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 8th day of July, 2019

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

Original report signed by the inspector.