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
May 21, 2021	2021_631210_0017	022768-20, 023585-20, 000554-21, 002213-21, 002244-21, 002285-21, 002691-21, 006316-21	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

SLAVICA VUCKO (210)

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): April 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, and 28, 2021.

The following intakes were completed in this complaint inspection:
Log #002285-21, Log #006316-21, Log #022768-20, Log #002691-20, Log #002213-21, Log #000554-21 and Log #023585-20 were related to personal support services, medication administration, infection prevention and control, and safe and secure home.

The following critical incident system (CIS) reports was inspected concurrently:
Log #002244-21 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Physiotherapist (PT), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Personal Support Workers (PSWs), Residents, and Family member.

During the course of the inspection, the inspector observed resident and staff interactions, reviewed clinical health records, home policies and procedures, and written complaints.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the developed strategies have been implemented to respond to the resident's responsive behaviours, where possible.

A complaint was submitted to the MLTC that a resident had not been assisted with activities of daily living (ADL) for a specified period.

The resident's cognitive status varied since admission, based on the home's assessments. Resident's hospital record showed a history of a disorder which appeared to be poorly controlled and affected the responsive behaviors of the resident.

The resident was independent for most of their activities of daily living (ADL). They were able to communicate with staff on a day-to-day basis. The resident was able to understand implications of daily care. The SDM of the resident communicated with them regularly.

As per the Substitute Decision Act 1992, a person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The resident had a history of worsening responsive behavior and increased refusal of personal care assistance. During a specified period, the home was in COVID-19 outbreak and residents were provided with a modified personal care. When the resident

was approached by staff for personal care they often refused and was able to provide personal care to themselves. If staff offered repeatedly assistance, the resident would present with responsive behaviour and the staff would leave them alone until resolved.

The Behavioural Support Services (BSS) Mobile Support Team assessed the resident on a specified date, several weeks before the home went into COVID-19 outbreak, and submitted a report to the home with recommendations for specific strategies with a goal to increase a personal care acceptance to at least once a week over three weeks. The home trialed some of the interventions and evaluated them as ineffective.

The home was not able to demonstrate that all of the strategies developed by the BSS team to respond to the resident's refusal of assistance with a specific personal care were implemented and evaluated.

Sources: resident's clinical record, Substitute Decision Act, interview with resident’s family member, interview with registered nurses, BSS team and other staff. [s. 53. (4) (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 strategies have been implemented to respond to a resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the bed rails were used for a resident, they were assessed and his or her bed system was evaluated to minimize risk to the resident.

A complaint and CIS report were submitted to MLTC that a resident fell on a specified date. They sustained injury and were sent to hospital as a result.

The resident did not have a history of recent falls and was able to walk. Several days before they fell they were treated for several acute health conditions. The resident had a history of responsive behaviour which according to the hospital assessment appeared to be poorly managed and affected the quality of every day living of the resident.

The resident lied in bed in a specific position, which was unique to the resident. The resident had quarter rails to assist with bed mobility and transferring.

As per the Clinical Guidance document for the assessment and implementation of bed rails in hospitals, long term care facilities, and home care settings developed by the Hospital Bed Safety Workgroup, dated April 2003, a decision to utilize bed rails should be informed by an individual patient assessment.

The bed safety assessments of the resident’s bed did not consider the resident’s individual assessment, including the resident's position in their bed related to the location of the bed rails. As a results the resident's bed rails may not have been appropriately placed due to their positioning.

Sources: resident’s clinical record, Clinical Guidance document (Hospital Bed Safety Workgroup, dated April 2003), interview with resident’s family member, registered nurses, physiotherapist and other staff. [s. 15. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

A complaint was submitted to the MLTC that a resident was not transferred as per their plan of care.

Following their return from hospital after a fall, the resident was assessed by the PT and they recommended the resident to not use the affected body part until further follow up. They required two-person assistance for specific activities of daily living.

On a specified date, the resident's family member requested assistance from staff with resident's activities of daily living. The staff transferred the resident by themselves. Two other staff also reported transferring the resident without assistance from another staff member. The resident did not suffer injuries.

The resident was not consistently transferred by two-person assistance for an identified period, according to the plan of care.

Sources: resident' clinical record, interview with resident's family member, registered nurse, physiotherapist, personal support workers and other staff. [s. 36.]

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.