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
Jun 2, 2016	2016_288549_0012	000830-15, 003334-15, 034105-15, 009365-16, 009773-16, 014708-16	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

SEVEN OAKS
9 NEILSON ROAD SCARBOROUGH ON M1E 5E1

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 2, 3, 4, 5, 6, 9,10, 11, 12, 13, 16 , 17, 2016

The following logs were inspected: #000830-15, 003334-15, 009365-16, 034105-15, 009773-16 related to Fall Prevention and 032513-15 related to Plan of Care

In addition, a Complaint Inspection was completed Log# 03192-14 related to plan of care. Additional information is identified under inspection #2016_288549_0011.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), two Nurse Managers (NM), the home's Behavioural Support Outreach Worker (BSO), Senior Administration Clerk, two Staffing Schedulers, the Director of Nursing (DON) and the Administrator.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to the resident.

The home submitted a Critical Incident Report (CIR) on a specific date in December 2015 indicating that resident #003 was being assessed by the RN on a specific date in December 2015 when the resident fell on to the floor from the bed. Resident #003 sustained a fracture.

Resident #003 was admitted to the home in May 2014. The resident is severely cognitively impaired as indicated in the Minimum Data Set dated a specific date in October 2015.

During an interview RN #134 indicated to Inspector #549 that both half bed rails are to be in the up position at all times. The RN indicated that fall mats are to be positioned on the floor on both sides of resident #003's bed as a new fall prevention intervention after the fall in December 2015.

During an interview on May 6, 2016 with resident #003's spouse it was indicated to Inspector #549 that the resident requires both half rails in the up position at all times and a fall mat on both sides of the bed at all times.

During an interview on May 9, 2015 PSW #125 and PSW #126 indicated that resident #003 requires both half bed rails to be in the up position at all times and a fall mat on both sides of the bed at all times.

During an interview on May 11, 2015, RPN #107 indicated to Inspector #549 that resident #003 is to have both half bed rails in the up position at all times and a fall mat on both sides of the bed.

On May 11, 2015 Inspector #549 observed resident #003 in bed with both half bed rails in the up position and a fall mat positioned on the floor on one side of the resident's bed. The other fall mat was rolled up against the wall across from the bed. RPN #107 was outside in the hallway across from resident #003's room when Inspector #549 observed only one floor mat beside the resident's bed. RPN #107 came across to the resident's room and indicated to Inspector #549 that there should be a fall mat on both sides of the resident's bed at all times. RPN #107 put the fall mat beside resident #003's bed and indicated that the resident was assisted with breakfast and the nursing staff forgot to put the fall mat back in place after the resident was assisted with breakfast.

Inspector #549 reviewed resident #003's current plan of care dated a specific date in May 2016. The plan of care indicated that resident #003 was a high risk for fall. Inspector #549 along with Nurse Manager #100 were not able to locate in the current plan of care that resident #003 requires to have both half bed rails up at all times or that there is to be a fall mat on both sides of the bed at all times.

In summary the plan of care does not set out clear direction to the staff who provide direct care to resident #003. [Log # 034105-15] [s. 6. (1) (c)]

2. The home submitted a CIR indicating on that on a specific date in November 2015, PSW #135 was assisting resident #011 to prepare for bed between 1900hrs and 2000hrs instead of the resident's usual 2230hrs.

Resident #011 was admitted to the home on a specific date in March 2015. The resident is cognitively well and requires one person physical assist with dressing and personal care as indicated in the Minimum Data Set assessment dated a specific date in September 2015.

During an interview with RN #134 on May 9, 2016 it was indicated to Inspector #549 that resident #011 usually goes to bed at 2230. RN #134 indicated that PSW #135 was providing bed time care to resident #011, putting the resident in night clothes at approximately 1900hrs when the resident does not go to bed before 2200hrs. RN #134 indicated that on a specific date in November 2015 resident #011indicated to her that the

new nurse tried to make him/her go to bed early and he/she refused.

PSW #133 indicated to Inspector #549 during an interview on May 10, 2015 that she provides care for resident #011 and is aware that the resident does not go to bed before 2200hrs every night.

During an interview on May 10, 2016 resident #011 indicated to Inspector #549 that he/she does not recall the specific incident however, indicated that he/she would refuse to go to bed before 2200hrs just because a PSW wanted him/her to go to bed.

On May 11, 2016 Inspector #549 reviewed the written plan of care last updated dated on a specific date in December 2015 which was the plan of care in place on the specific date in November 2015 with RPN #136. Inspector #549 was unable to locate on the written plan of care resident #011's sleep patterns and preferences.

During an interview on May 17, 2016 PSW #135 indicated to Inspector #549 that she did not assist the resident to bed between 1900hrs and 2000hrs . PSW #135 indicated during the interview that she did get resident #011's night clothes ready for later and possible resident #011 misunderstood her.

On May 12, 2016, RPN #136 and Inspector #549 reviewed the current written plan of care, last updated on a specific date in January 2016 and were unable to locate resident #003' sleep preferences on the current written plan of care or the plan of care that was in place on the specific date in November 2015.

In summary the plan of care does not set out clear direction to the staff who provide direct care to resident #011 related to the residents sleep preference. [Log#032513-15] [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted a CIR on a specific date in November 2015 indicating that resident #008 was to have the dinner meal in the resident's room. PCA #135 did not pre-order the resident's meal choice, the resident did not like what was offered and did not eat a dinner meal.

Resident #008 was admitted to the home on a specific date in May 2012. The Minimum

Data Set assessment dated a specific date in November 2015 indicates that the resident is moderately impaired with some short term memory problems.

On May 13, 2016 during an interview resident #008 indicated to Inspector #549 that he/she recalls the evening when he/she became mad at the new nurse. The resident indicated that PSW #135 did not bring the meal tray with the food choice he/she had requested. Resident #008 indicated that the PSW took the food and left the resident's room. The resident then indicated that PSW #135 brought the same food back after it was heated and he/she became upset because the food was not what he/she had ordered. Resident #008 indicated that when PSW #135 brought the food back to him/her after the PSW warmed it up PSW #135 tried to feed him/her and he/she became very angry and started yelling at the PSW. PSW #135 left the room again with the meal tray. Resident #008 indicated to Inspector #549 that he/she went out in the hallway following the PSW and was yelling at PSW #135 when RN #134 came down the hallway.

During an interview on May 10, 2016, PSW #133 who provides care to resident #008 indicated to Inspector #549 that resident does not require assistance to eat at meal times.

During an interview on May 13, 2016, PSW #140 and RPN # 118 indicated that resident #008 has always eaten meals without assistance.

During an interview on May 17, 2016 PSW #135 indicated that she went back to resident #008 and apologized and offered him/her something different to eat but the resident refused.

Inspector #549 reviewed the plan of care last updated on a specific date in September and the current plan of care dated a specific date in January 2016 both indicated that resident #008 required set up only for eating.

In summary the plan set out in the plan of care related to eating was not provided to resident #008 as specified in the plan. [Log# 032513-15] [s. 6. (7)]

4. The home submitted a CIR indicating on a specific date in November 2015, resident #012 was observed by RN #134 and RPN #136 in the hallway outside the residents room.The CIR also indicates that the resident stated that he/her had been left on the toilet for 10, 20, 30, 60 minutes. The resident is a high risk for falls and is to be in his/her wheelchair at the nursing station for close monitoring as the resident attempts to stand

without assistance.

Resident #012 was admitted to the home a specific date in January 2015. The Minimum Data Set assessment dated on a specific date in October 2015 indicates that resident #012 required extensive assistance to walk in room and corridor with two person physical assist, dressing total assistance with one person physical assist and toilet use total assistance with one person physical assist, incontinent of urine and requires briefs. Resident #012's cognitive performance scale (CPS) is three, the resident is usually able to make self-understood and no issue with understanding others.

On May 9, 2016 during an interview RN #134 indicated to Inspector #549 that on a specific date in November 2015 she was the charge RN on resident #012's unit. RN #134 indicated that she observed resident #012 walking out of his/her room. RN #134 indicated that the resident indicated to her that he/she was assisted to the toilet and left there for an hour.

On May 11, 2016 during an interview RPN #136 indicated to Inspector #549 that on a specific date in November 2015, she was the charge RPN on resident #012's unit. RPN #136 indicated that she observed resident #012 walking out of his/her room. RPN #136 indicated that the resident indicated to her that he/she was assisted to the toilet and left there for an hour.

RPN #136 indicated that resident #012 was high risk for falls and was not to be left alone in the washroom. RPN #136 also indicated resident #012 was to be at the nursing station when the resident is not in bed or restless for close observation due to high risk of falls.

RN #134 and RPN #136 indicated during the interviews that PSW #135 was assigned to provide care to resident #012 on the specific date in November 2015.

Inspector #549 reviewed the care unit assignment sheet which indicated that PSW #135 was assigned to provide care to resident #012.

During an interview on May 17, 2016 PSW #135 indicated to Inspector #549 that resident #008 was left unattended on a specific date in November 2015 in his/her room as the PSW needed to get an incontinence brief for the resident from the care cart.

Resident #012's written plan of care dated a specific date in October 2015 which was in

place on the specific date in November 2015 indicated the following; resident #012 is at a risk/high risk for falls, as evidenced by unsteady gait, frequent falls. Requires two person physical assist to walk in corridor. Toilet use: extensive assistance, weight bearing help to take resident to washroom and staff stay with the resident for safety. Dressing: total assistance, full staff performance due to resident will lose concentration, one person assist.

In summary the care set out in the plan of care related to toileting was not provided to resident #012 as specified in the plan. [Log# 032513-15] [s. 6. (7)]

5. The home submitted a CIR indicating that on a specific date in November 2015 resident #007 was assisted to bed and then fed supper. The resident eats with assistance in the dining room unless the resident is ill. The resident was assessed on a specific date in September 2015 to be a moderate nutritional risk.

Resident #007 was admitted to the home on a specific date in July 2010. The resident is cognitively impaired as indicated in the Minimum Data Set assessment dated a specific date in September 2015.

On May 10, 2015, during an interview PSW #133 indicated that on a specific date in November 2015 PSW #135 asked for assistance with putting resident #007 to bed before dinner. PSW #133 indicated that she informed PSW #135 that resident #007 eats meals in the dining room. PSW#133 indicated that PSW #135 told her that she was going to feed the resident dinner in bed. The two PSWs assisted the resident to bed using the mechanical lift before the dinner meal.

During an interview on May 10, 2016 RN #134 indicated that she was upset that PSW #135 feeding resident #007 in bed when the plan of care specifically says resident #007 is to eat in the dining room. RN #134 indicated that the resident may only be fed in his/her room if his/her is not capable but this was not the case on the specific date in November 2015.

During an interview with RPN #118 on May 11, 2016 it was indicated to Inspector #549 that resident #007 eats all meals in the dining room unless he is ill. RPN #118 indicated to Inspector #549 that the resident was not ill on the specific date in November 2015.

On May17, 2016 during an interview PSW #135 indicated that she does not recall if resident #007 was assisted to eat while in bed.

Inspector #549 observed resident #007 eating lunch and dinner in the dining room on May 10, 11 and 12, 2016.

Resident #007's plan of care last updated on a specific date in September 2015 indicated that the resident eats in the dining room for meals. The resident requires extensive assistance with eating. Staff to cut meat, open packages pour fluids and verbally encourage the resident to east slowly and swallow safely due to his/her cognitive impairment. The resident will feed himself/herself but is very slow. Staff will feed him/her the remainder of his/her meal if he/her has not completed it. In the evenings the resident needs to be fed by one staff most of the time due to increase in shaking.

In summary the care set out in the plan of care related to eating was not provided to resident #007 as specified in the plan. [Log # 032513] [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to Log# 003192-14 resident #001

Resident #001 was admitted to the home on a specific date in June 2014. The resident is cognitively impaired as indicated in the Minimum Data Set (MDS) assessment dated a specific date in February 2016.

Resident #001 was assessed on a specific date in August 2014 and found to be incontinent of urine. The resident was measured at that time by nursing staff and required a large size incontinent product. The resident's preferred type of incontinent product was a pull-up.

The Minimum Data Set assessment (MDS) dated a specific date in February indicated that the resident requires extensive assistance with toileting and wears an incontinent product. One person physical assist to take the resident to the toilet, is forgetful and needs to be reminded.

The home provides TENA incontinent products for residents use. On each care unit there is a TENA product usage sheet which PSW's refer to. The TENA product sheet indicates the resident's name, the preferred product type and the size for day, evening and night wear.

Inspector #549 reviewed the care unit TENA product sheet dated a specific date in January 2016 for resident #001on May 3, 2016. RPN#102 indicated to Inspector #549 that the January 2016, TENA product sheet was the current sheet used by the PSW's.

The TENA product sheet for resident #001 showed a pen line crossing out the large pull-up and replaced it with a medium pull-up.

On May 3, 2016 during an interview with resident #001's family member it was indicated to Inspector #549 that the resident is often given a medium pull-up to wear and they will ask the staff to exchange the medium for a large. The family member indicated to Inspector #549 that the resident needs a large pull-up and has discussed the issue with the TENA champion on the care unit.

On a specific date in May 2016 the family member indicated to Inspector #549 that the resident was provided with a medium pull-up to wear. The family member went to the PSW to exchange the medium pull-up for the large pull-up.

Review of resident #001's current plan of care last updated on a specific date in March 2016 indicates that the resident uses TENA blue size large daily.

During an interview with RPN #102 on May 3, 2016, it was confirmed with Inspector #549 that the current TENA product sheet indicated that resident #001 is to be provided with a medium pull-up to wear however, the plan of care indicates a large pull up. RPN #102 indicated that she is aware that resident #001 wears a large pull-up as the plan of care indicated. RPN #102 indicated that she will speak to the nursing staff and correct the TENA product sheet immediately.

In summary the care set out in the plan of care related to continence care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

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 the written plan of care sets out clear directions to staff and others who provide care to resident #003 and #011. To ensure that the care set out in the plan of care is provided to resident #001, #007 and #008 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is notified no later than one business day after the occurrence of the incident of an incident that causes an injury to a resident that results in a significant change in the resident's health and for which the resident is taken to a hospital.

The home submitted CIR on a specific date in February 2016. The CIR indicated that the charge RN was called to assess resident #004 after the resident had an unwitnessed fall. Impairment to the a hip was evident. The charge RN made the decision to transfer the resident to hospital for further assessment on a specific date in January 2016.

Inspector #549 reviewed the resident's progress notes dated a specific date in January 2016 which indicated that the nursing staff at the home called the hospital on the same specific date in January 2016 and was informed by the emergency department staff that resident #004 was being admitted with a diagnosis of a hip fracture that required surgical repair. Resident #004 returned to the home on a specific date in February 2016.

Nurse Manager #100 indicated that she became aware that the Director was not notified no later than one business day when she returned from vacation in February 2016. Nurse Manager #100 indicated that she then informed the Director using the Ministry of Health and Long Term Care Critical Incident Reporting system on a specific date in February 2016 which was 20 days following the incident.

On May 4, 2016 during an interview Nurse Manager #100 indicated that the home's expectation is that the charge RN notify the Director no later than one business day following an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

In summary the home failed to inform the Director no later than one business day after resident #004 had a fall resulting in admission to hospital with a hip fracture requiring surgical repair. [Log # 009365-16] [s. 107. (3)]

Issued on this 6th day of June, 2016

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

Original report signed by the inspector.