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
May 31, 2016	2016_219211_0009	011798-16, 025064-15, 031675-15	Complaint

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

JOELLE TAILLEFER (211)

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): May 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 2016

The following logs were inspected: #025064-15-16, 031675-15, 011798-16 related to alleged abuse, continence care and care conference
Summary statement: Please note the finding of non-compliance r. 104. (2) for resident #022 in this concurrent inspection is related to Log #015294-16 in the Critical Incident System inspection # 2016_219211_0008

During the course of the inspection, the inspector(s) spoke with with residents, resident's POA, Personal Support Workers (PSW), Housekeeping Staff, Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapist, Recreation Services Assistant (RSA), two Nurse Managers (NM), Acting Nurse Manager (ANM), Councillor, Senior Administration Clerk, two Staffing Schedulers, the Director of Nursing (DON), and the Administrator.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to intervention are documented.

This following finding is related to Log #011798-16.

Review of the written plan of care on an identified date, and interviews with PSW #128 and PSW #127 indicated that resident #027 requires assistance with continence care.

Interview with the family and review of the resident's report, indicated resident #027 was observed incontinent on two identified dates.
PSW #129 reported to the inspector that continence care was provided on a specified date but that she/he failed to document the care provided.

A review of the residents Nursing and Personal Care Record (NPCR) confirmed that continence care was not documented on a specified date.

Interviews with NM #100 and DON confirmed the PSW did not document that resident #027's continence cares was provided for on the identified date and the continent interventions should have been documented in the NPCR.

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to intervention are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

This following finding is related to Log #011798-16.

Review of the home e-mail on an identified date, from the administrator to the NM #119 indicated she received a phone call from resident #027's family with multiple complaints.

An e-mail sent on an identified date by the NM #119 to the Administrator indicated the Critical Incident Report (CIS) was initiated related to basic care, services and to address an alleged abuse.
Review of the resident's CIS and interviews with the above NM and the Administrator confirmed the alleged abuse was not report to the Director until twelve days later.

This following finding is related to Log #015294-16 in the Critical Incident System inspection #2016_219211_0008.

Interview of the ANM revealed she received the letter of alleged inappropriate behaviours about resident #022 toward resident #29 at the end of the day on a specific date. On the same date at the end of the afternoon an email was sent from the ANM to the Administrator informing she will notify the MOH of the alleged abuse and will follow up with an investigation.

Interview with the housekeeping staff #145 revealed that resident #032 reported the incident on the above date during the morning and the letter was given to the ANM's office on the same day.

Interview with the Assistant Administrator revealed she was informed by AMN on the above date, related to the inappropriate behaviour by resident #022 toward resident #029 and told the AMN to notify the Director and to start the Critical Incident Report (CIS).

Interview with NM #100 confirmed the Critical Incident Report (CIS) was not completed within 10 days of becoming aware of the alleged abuse.

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 the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

This following finding is related to 011798-16.

Review of the resident #027's current plan of care indicated the resident was admitted on an identified date.

Interview with the councillor #143 revealed the family was called during the ninth weeks (after sixty-nine days) to book a care conference on an identified date.
Interview with the DON confirmed the resident's care conference was not provided within the six weeks following resident admission.

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.