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
Mar 17, 2017	2017_626501_0003	016543-16	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

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): February 8, 9 and 10, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Nurse Managers (NMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager (ESM), Food and Nutrition Manager, housekeeping/laundry aide, dietary aide and substitute decision maker (SDM).

The following Inspection Protocols were used during this inspection:

Personal Support Services
Reporting and Complaints

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. (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 the care set out in the plan of care is provided to the resident as specified in the plan.

An observation on February 8, 2017, revealed resident #001 was served a lunch tray which included an entrée of a cottage cheese fruit plate. Resident #001 only had a few bites.

Record review revealed resident #001 is at nutritional risk due to inadequate intake. The written plan of care states do not serve cottage cheese. Interview with dietary aide #105 revealed he/she had not checked the dietary list before preparing a tray for resident #001.

Interview with the Food and Nutrition Manager revealed he/she was aware resident #001 does not like cottage cheese and confirmed that the care set out in the plan of care was not provided to the resident 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

An interview with resident #001's Substitute Decision Maker (SDM) revealed that he/she brought a new identified item of clothing for his/her mother/father and it has gone missing. The SDM further stated he/she had called the Building Services Manager (BSM) and left messages but has not received a reply.

Review of resident #001's medical record on the unit revealed that an identified item of clothing was recorded as being brought in on the home's Record of Clothing and Personal Effects on an identified date. Interview with RPN #102 revealed he/she signed

this form as having received the item.

An interview with laundry/housekeeping aide #103 revealed he/she remembers speaking with resident #001's SDM on an identified date, and recorded this on a small piece of brown paper which he/she showed the inspector. The aide told the inspector that usually they document lost clothing on a form but in this case had failed to do so.

An interview with the Building Services Manager (BSM) on an identified date, revealed that it is the practice in the home for all lost or misplaced personal items to be recorded on a form specifically designed for such items which is then tracked for quality improvement purposes. The BSM admitted he/she had not checked his/her telephone messages recently and while the inspector was in his/her office found that a message had been left for him/her from resident #001's SDM from an identified date, stating he/she had left a message the previous week and was waiting to hear what happened to his/her mother's/father's item of clothing. The BSM then spoke with the laundry/housekeeping aide and searched the home for the missing item. The BSM thought he/she had found the missing item by checking a resident's room with the similar name which is one of the suggested areas to check on the home's form. The BSM stated he/she was going to respond to the complainant that day, 14 days after the laundry/housekeeping aide first received the complaint.

The BSM confirmed the home had not responded to resident #001's SDM within 10 business days of his/her complaint. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint.

An interview with resident #001's SDM revealed he/she often communicated with the home via email with the Nurse Manager (NM). The SDM mentioned he/she had a concern regarding the continuity of care and had emailed NM #101 regarding this in an identified month. The SDM was also very upset and emailed the same NM two months later with many issues regarding personal care.

Interview with Nurse Manager #101 revealed he/she was aware of resident #001's concern regarding continuity of care and stated he/she had spoken with the SDM but had no written notes regarding this conversation. The NM provided the inspector a copy of the email that the SDM had sent after asking their Information Technology (IT) department to retrieve emails from this SDM.

Interview with Nurse Manager #101 revealed he/she never received an email regarding resident #001’s concerns regarding personal care and IT could not find such an email. Interview with the SDM revealed an email was sent to the NM on an identified date, according to his/her records and provided the inspector with a copy.

An interview with NM revealed he/she had not kept records of each verbal and written complaint regarding resident #001. [s. 101. (2)]

Issued on this 20th day of March, 2017

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

Original report signed by the inspector.