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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 22, 2018	2018_598570_0010	009689-18	Resident Quality Inspection

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

SAMI JAROUR (570), CAROLINE TOMPKINS (166), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 23, 24, 25, 28, 29, 31, June 1, 4, 5, and 6, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Manager of Resident Services (MRS), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), MDS-RAI coordinator, Practical Care Aides (PCA), Physiotherapist (PT), Occupational Therapist (OT), Heavy Duty Cleaners, Family Council president, Residents' Council president, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed resident care and staff to resident interaction, observed resident to resident interactions, observed medication administration, provision of care, reviewed identified residents' clinical records, Family Council and Residents' Council meeting minutes, cleaning schedule of ambulation equipment and relevant licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care for each resident, sets out the planned care for the resident.

Related to resident #016:

During stage one of the Resident Quality Inspection (RQI), the use of two identified devices by resident #016 was triggered as potential restraints.

During an observation in May 2018, Inspector #570 observed resident #016 seated reclined with an identified device securing the resident's specified body part in a specified position.

During observations in June 2018, Inspector #570 observed resident #016 seated with an identified device applied to secure the resident's body part in a specified position. Inspector #570 observed PCAs #115 and #116 removing the identified device and repositioning resident #016; both PCAs reapplied the identified device. Later that day, Inspector #570 observed resident #016 being assisted in mobility device by staff while seated with the identified device applied holding a specified body part in position.

The current written plan of care for resident #016 was reviewed by Inspector #570. The

plan of care review did not indicate that the resident used the identified device which was noted in use.

During an interview, PCA #128 indicated to Inspector #570 that resident #016 used an identified device to hold a specified body part in place while seated.

During separate interviews, PCAs #115, #116 and #119 indicated to Inspector #570 that the identified device was used to keep resident #016's body part in position for safety. The PCAs indicated that the resident always had the identified device applied when sitting. The PCAs further indicated that they were instructed verbally by either the Physiotherapist or the Occupational Therapist in applying the identified device and that there were no instructions to be found in the resident's plan of care regarding the use of the device.

During an interview, RN #117 indicated to Inspector #570 that resident #016 used a specified mobility device as a personal assistance service device (PASD). RN #117 further indicated that resident #016 could not move their specified body part and used an identified device to keep proper position when seated. Upon review of the resident's current written plan of care, the RN confirmed that the use of the identified device was not included in the resident's written plan of care.

During an interview, both the Occupational Therapist (OT) #129 and the Physiotherapist (PT) #118 indicated that they decided to use an identified device for resident #016 for safe positioning and to prevent injury to the resident. Both the OT and PT indicated that the use of the specified device was not included in the written plan of care and had verbally instructed staff about the application of the device and informed the charge nurse to include the use of the device in the resident's written plan of care. Both PT and OT indicated that the use of the identified device should be included in the resident's written plan of care.

During an interview, the Director of Nursing (DON) indicated to Inspector #570 that it is an expectation that care provided to resident #016 including the use of the identified device should be included in the resident's written plan of care.

The licensee did not ensure that the written plan of care for resident #016 set out the planned care for the resident, specific to the use of the an identified device when seated. [s. 6. (1) (a)]

2. The licensee had failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Related to resident #017:

During stage one of the RQI, resident #017 was identified for requiring specified care.

Observations of the resident during the course of this inspection identified they used a mobility device.

Review of resident #017's written plan of care, with specified date, indicated resident #017 used a specified product, and staff were directed to provide the specified care to the resident with the assistance of one staff at identified times.

Review of resident #017's clinical records identified a progress note with a specified date and time, and a referral form for physiotherapy on a specified date, indicated a physiotherapy assessment had been requested to assess if the resident was able to toilet. The physiotherapy assessment identified that for resident's safety, a mechanical lift transfer was recommended. The documentation indicated that the registered nurse (RN) had been informed.

Interview with resident #017 identified they received specified care with one staff assistance. Resident confirmed the use of a mechanical lift for all transfers the first time on a specified later date.

Staff interview with PCA #131, identified that resident #017 required assistance for specified care. PCA #131 reported that they were informed on the evening shift report on this day, of resident #017's change in transfer status, reporting that resident #017 was changed from a one person assisted transfer to a two person full mechanical lift for transfers on a specified date.

Review of resident #017's written plan of care at the nursing station in the NPCR binder with PCA #131 identified resident #017's ADL statement was updated on a specified date to indicate they required total dependence, two staff assistance with a mechanical lift for all transfers. Resident #017's specified care statement in the care plan remained unchanged as noted above at the time of this review of the written plan of care.

Interview with RN #130 confirmed they were made aware on this day that resident #017 was a two person with mechanical lift for all transfers. The above noted frontline staff report and documentation including resident #017's plans of care and physiotherapy assessments were reviewed with RN #130. RN #130 confirmed resident #017 received a one person transfer up until a specified date, despite the change in transfer level as assessed by physiotherapy on an earlier specified date. RN #130 confirmed resident #017 was not provided appropriate care as per their assessed needs when being transferred. RN #130 was unable to clarify why the physiotherapy assessment determined as of earlier specified date, was not implemented until a later date.

The above staff reports and documentation were reviewed with the home's Nurse Manager (NM) #127. NM #127 reported that they had been made aware that the home's physiotherapy department had not informed the RN at the time of the assessment on a specified date, of the change of transfer method for resident #017. NM #127 stated the physiotherapy documentation, identified that an RN had been informed. However, as per NM #127, on that same specified date, only two RPN staff were on duty in resident #017's home area. NM #127 stated that physiotherapy staff confirmed they did not report the change in the transfer method for resident #017 to registered staff on that same date, and therefore, it had not been communicated to the care team until a later specified date. NM #127 confirmed resident #017s' plan of care had not been revised to reflect their assessed needs for a specified period.

The licensee did not ensure that the written plan of care for resident #017 was revised specific to transfer status when the resident's care needs changed. (648) [s. 6. (10) (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 the written plan of care for each resident, sets out the planned care for each resident; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 23rd day of August, 2018

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

Original report signed by the inspector.