**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 prévue 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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 8, 2019 | 2019_486653_0003 | 021050-17 | Complaint |

**Licensee/Titulaire de permis**

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

**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**

ROMELA VILLASPIR (653)

## 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): January 22, 23, 24, 25, 29, 30, 31, February 1, and 4, 2019.**

**During the course of the inspection, Complaint Log #021050-17 related to an injury sustained from unknown cause and a change in resident #007's condition, had been inspected.**

**During the course of the inspection, the inspector reviewed staff schedule, clinical health records, and relevant home policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Nurse Managers Operational (NMOs), and the Director of Nursing (DON).**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to resident #007 sustaining an injury from an unknown cause and experiencing a change in their condition. The complainant indicated the resident was neglected and not properly cared for.

A review of resident #007’s progress notes revealed they had been admitted to Seven Oaks on an identified date. Further review of the progress notes revealed resident #007 had an identified medical device.

A review of the home’s 24hr nursing report on an identified date revealed documentation from two different shifts, of a change in resident #007's condition.

A review of resident #007’s progress note on an identified date, revealed Registered Practical Nurse (RPN) #124 had received report that during the prior shift, the resident had interfered with their medical device and started to exhibit a change in their condition. RPN #124 notified the physician and the physician suggested to send the resident to the hospital for further assessment, which was agreed upon by the Substitute Decision-

Maker (SDM).

A review of the Paramedic Services report, revealed the paramedics had attended to resident #007 and the nursing home staff stated the resident had interfered with their medical device the day before, and since then a change in their condition had been noted.

Separate interviews held with Personal Support Workers (PSWs) #127, #129, RPNs #124, #125, and Registered Nurses (RNs) #126, #128, who worked on an identified shift, indicated they could not recall the resident nor the above mentioned incident. During an interview, RN #126 reviewed the 24hr nursing report with the inspector, and the RN stated that based on the documentation, resident #007 interfered with their medical device resulting in a change in their condition. The RN further indicated that the physician should have been notified immediately.

During an interview with the Director of Nursing (DON), the nursing report and progress notes related to resident #007 had been reviewed with the inspector, and the DON indicated that the registered staff working on the identified shift should have escalated the situation to the physician once they had observed a change in the resident's condition.

The licensee had failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #007 so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee had failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A telephone interview with the complainant indicated resident #007's family was not notified when the resident sustained an alteration in skin integrity. A follow-up e-mail from the complainant revealed that on an identified date and time, resident #007's SDM had arrived in the home and found the resident alone in the hall outside their bedroom. The SDM noted the alteration in skin integrity on resident #007's body and had asked RPN #124 what happened, and there was no explanation provided to the SDM.

A review of resident #007's progress note from an identified shift, revealed the PSW

reported to RPN #124 that the resident had an alteration in skin integrity and was treated. Resident #007's family had visited.

Separate interviews held with PSWs #127, #129, RPNs #124, #125, and RNs #126, #128, who worked on the identified shift, indicated they could not recall the resident nor the above mentioned incident. RPN #125, RNs #126, and #128 indicated that when residents sustain an alteration in skin integrity, an incident report had to be filled out by the registered staff, the SDM had to be notified, and they would have to document on the progress notes. The registered staff further indicated there was a section on the incident report form for notification of the family.

Further review of resident #007's health records did not identify an incident report had been filled out for the alteration in skin integrity.

During an interview with the DON, the 24hr nursing report and progress notes related to resident #007 had been reviewed with the inspector, and the DON acknowledged that in this case, resident #007's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care when they had not been notified of the alteration in skin integrity.

The licensee had failed to ensure that resident #007's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

***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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and***
***-that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care, to be implemented voluntarily.***

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**Issued on this 9th day of April, 2019**

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

**Original report signed by the inspector.**