Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2019	2019_714673_0008	000954-18, 005920-18, 008858-18, 013866-18, 022767-18	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 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

BABITHA SHANMUGANANDAPALA (673), GORDANA KRSTEVSKA (600), PRAVEENA SITTAMPALAM (699)

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): August 21-23, and August 26-29, 2019

The following intakes were completed in this Critical Incident System Inspection:
-Log #000954-18, CIS #M571-000002-18 and Log #022767-18, CIS #M571-000036-18, related to resident to resident physical abuse and responsive behaviours
-Log #013866-18, M571-000024-18 and Log #005920-18, CIS #M571-000008-18, related to resident to resident sexual abuse and responsive behaviours
-Log #008858-18, CIS #M571-000014-18, related to infection prevention and control

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19, and a Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10, s. 221 (2) were identified in this inspection and have been issued in Inspection Report 2019_714673_0007, dated October 29, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim Director of Care (IDOC), Nurse Managers (NM), Manager of Resident Services (MRS), Food and Nutrition Manager (FNM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behvioural Support Team Staff (BSO), Pharmacy Consultant (PC), family members and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, medication administration observations, resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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	Légende 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care (MLTC) related to resident to resident physical abuse. A review of the CIS report and resident's progress notes indicated that on an identified date and time, resident #010 entered an identified common room in their identified mobility device and pushed resident #011, who was sitting in their wheelchair at a long table. The force from the impact pushed the long table against the wall and resident #011 sustained an identified injury on an specific area of the body caused by hitting the edge of the table.

A request to review the home's investigation documents identified that other than what was documented in the resident's progress notes and CIS report, no other documentation was kept to indicate that the home had investigated the incident of abuse.

In an interview, the BSO lead RPN #110 stated that the practice in the home was for nursing staff to conduct investigations related to any incident of resident to resident

physical abuse. The BSO lead further stated that they went to talk to resident #010 the morning after the incident, but the resident did not want to talk about what had happened. The BSO lead also stated that they did not talk to any other staff regarding the incident.

In an interview, RN #113 indicated that at the time of the incident, they were present on the floor administering medication. According to RN #113, resident #011 was in the identified common room sitting in a regular chair which was facing the wall. Resident #010 maneuvered their identified mobility device into resident #011, who then hit the table with their body which in turn resulted in the table hitting the wall and making a loud noise. RN #113 stated that on assessment they identified that resident #011 was harmed and was complaining of pain. RN #113 was not able to provide an explanation as to why resident #010 hit resident #011.The RN stated that after resident #010 refused to talk to them during their initial attempt, they did not proceed to further investigate with staff to identify whether there had been a trigger for resident #010's behaviour towards resident #011. The RN also stated that these two residents had never had any previous arguments nor spent time together and that staff were not aware of what triggered resident #010's behaviour during this incident.

In an interview, NM #102 acknowledged that the home did not investigate the incident of resident to resident physical abuse involving residents #010 and #011. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the information gathered on every shift (of the monitoring of symptoms indicating the presence of infection in residents and immediate actions taken) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infections and outbreaks.

A CIS report was submitted to the MLTC related to a identified outbreak. A review of the report indicated that the home had identified nine residents suspected of an identified illness, and that two residents had been positive for a specific diagnosis. No staff were reported to be affected.

A review of the home's Infection Prevention and Control Program (IPAC) records indicated that the home had reported identified outbreaks on eight separate dates. A review also indicated that no information about the identified outbreak on a specific date was analyzed or reviewed. Further review of the IPAC record showed no analysis or review was implemented for any of the outbreaks listed above.

A review of the home's IPAC records that also included the HAC and MAC meetings records, did not indicate that information gathered each shift about residents' infections, were analyzed daily to detect the presence of infection or that they were reviewed at least once a month to detect trends to reduce the incidence of infections and outbreaks.

A record review of the Annual Clinical Program Evaluation (ACPE) of the home's IPAC program on a specific date indicated that the home recognized that the IPAC program did not meet all its objectives. Under factors identified for improvement, the home stated that they developed a process to collect and analyse consistent data in a timely manner, dedicated an IPAC team with membership from the multidisciplinary team with regularly scheduled meetings.

In an interview, NM #115 indicated that they had an administrative role in nursing management, and their responsibility in the IPAC program as a manager included ensuring the adequate supply of personal protective equipment (PPE) for staff, and replacing staff, but not managing outbreaks from a clinical perspective.

In an interview, NM #102 indicated that they had a clinical role in nursing management, but that they did not have monthly meetings, and did not attend the quarterly IPAC meetings.

In interviews, both, NM #115 and NM #102, indicated that the Director of Nursing (DON) was the IPAC program lead, but the DON was not able to provide more information regarding the outbreak management. Both NMs stated that during outbreaks they follow the policy for managing the outbreak and document along the way. However, they acknowledged that the information collected every shift were not analyzed or reviewed monthly, so they did not have records for that. [s. 229. (6)]

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 information gathered on every shift (of the monitoring of symptoms indicating the presence of infection in residents and immediate actions taken) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infections and outbreaks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that written records were created and maintained for resident #018 and #020.

On an identified date, the MLTC received a CIS report related to the sexual abuse of resident #019 by resident #018. Both residents were separated and the dementia observation system tool (DOS) was initiated.

A second CIS report was submitted to the MLTC related to sexual abuse by resident #018 to resident #019. Both residents were separated, and DOS was initiated.

A record review of resident #018's and #020's progress notes indicated that on an identified date, DOS monitoring was initiated for both residents after the incident.

In an interview, BSO RPN #129 stated they could not locate resident #018's nor resident #020's DOS monitoring records which were initiated on an identified date.

In an interview, NM #102 acknowledged that resident #018's and #020's records were not kept in the home. [s. 231. (a)]

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.