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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2012	2012_196157_0009	001504,002388,002381, 002362	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)

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): December 4, 5,6, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DOC), Nurse Manager, 3 Registered Practical Nurses (RPN), 3 Personal Support Workers (PSW), the Recreational Manager and the front desk receptionist.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, internal incident reports, six critical incident reports reviewed facility policies related to risk for wandering, falls prevention, responsive behaviours and completion of Plans of Care, reviewed the 24 hour nursing report, observed the Co-Tag monitoring system, observed the provision of resident care and staff:resident interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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).

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 resident's plan of care fails to set out clear direction to staff and others who provide direct care to the resident.
Plan of care for resident #05 does not provide clear direction to staff by providing a specific description of the resident's actions when exhibiting abusive, anxious and agitated behaviours. [s.6.(1)(c)]

2. The plan of care for resident #08, confirmed by staff to be in place at the time of the reported critical incidents does not provide clear direction to staff by providing a specific description of the resident's actions when exhibiting abusive, resistive, agitated behaviours. [s.6.(1)]

3. The plan of care for resident #03 confirmed by staff to be in effect at the time of the reported incident, does not provide clear direction to staff by providing a specific description of the resident's actions when exhibiting identified behaviours.[s.6.(1)(c)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan:

The plan of care for resident #03 confirmed by staff to be in effect at the time of the reported incident directs that resident #03 will be supervised by staff with specific, identified activities. A Critical Incident Report was submitted detailing that the resident was involved in the identified activities without the supervision of staff.
There is no evidence of staff supervision as directed by the plan of care.[s.6.(7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed:
The plan of care for resident #01 does not identify exit seeking behaviours or strategies/interventions to manage that behaviour.
Progress notes for resident #01 identify two dates when that the resident was found unsupervised outside of the building.
The plan of care for resident #01 was not revised to reflect the risk for wandering until after the above noted incidents occurred.[s.6.(10)]

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 plans of care provide clear direction to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided as specified in the plan and to ensure that the plan of care is reviewed or revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers were identified in the plan of care for three identified residents demonstrating responsive behaviours.[s. 53. (4)(a)]

2. The licensee failed to ensure that residents demonstrating responsive behaviours are assessed and responses to interventions are documented in order that actions can be taken to respond to the needs of the resident.
The Licensee's policy "Behavioural Response - Care strategies" RC-0517-07 dated August 01, 2010 directs staff to:
"Complete DOS (Modified Dementia Observational System) in order to gain a better insight and understanding of the time and antecedents leading to behavioural response outbursts."
Progress notes for resident #03 indicate that the resident demonstrated identified behaviour on the unit.
A review of the resident's clinical health record and interview of the unit RPN confirms that DOS charting not was completed for this resident during this period.[s. 53.(4)(c)]

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 each resident demonstrating responsive behaviours has behavioural triggers identified and that actions are taken to respond to the needs of the resident, including assessment, and that the resident's responses are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had reasonable grounds to suspect the abuse of a resident and failed to immediately report the information to the Director:
A physical assault between two identified residents was confirmed to have occurred. The nurse manager confirmed that the incident was not immediately reported to the Director. [s.24.(1)]

Issued on this 12th day of December, 2012

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

Pat Rivers #157 Chantal Lafleneere (194)