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 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 18, 2018	2018_526645_0011	020204-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Demetrius (Ukrainian Catholic) Development Corporation
60 Richview Road ETOBICOKE ON M9A 5E4

Long-Term Care Home/Foyer de soins de longue durée

Ukrainian Canadian Care Centre
60 Richview Road ETOBICOKE ON M9A 5E4

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

DEREGE GEDA (645), SLAVICA VUCKO (210)

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): August 10, 13, 14, 15, 17, 21, 22, 23, 24, 27, 28, 29, 30, and 31, 2018.

During the course of the inspection, the following Critical Incidents and complaint intakes were inspected:
- Intake #003395-17 and #022634-17: related to incident of fall and
- complaint intake #027562-17, related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care, Resident Assessment Instrument (RAI) Coordinator, Documentation Nurse (DN), Infection Control Nurse, Social Worker (SW), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, record review of residents' and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

A complaint was submitted to the Ministry of Health and Long Term care (MOHLTC) indicating that the Social Worker (SW) #101 did not listen to the resident's concerns regarding managing their finances.

During an interview with the complainant, they indicated that they approached SW #101 and requested to be present in resident #006's room during the discussion, because the resident had questions to ask.

Interview with SW #101 revealed that the resident was admitted in the home on an identified date. According to the SW when they were approached by the complainant and asked to speak to the resident, they refused because the Executive Director (ED) had directed the SW not to be a witness in discussions between the resident and the complainant. The SW further stated that the complainant wanted them to listen to the resident talking about other identified financial concerns.

Review of resident #006's clinical record indicated that the complainant was the resident's Substitute Decision Maker (SDM) since 2012. According to the complainant, the resident felt disrespected and neglected because SW #101 refused to listen to resident's issues.

Interview with the DOC indicated that the expectation is if a resident has questions or would like to express concerns staff should make time to listen to the resident and correspond accordingly.

Interview with SW #101 confirmed they did not take time nor did they make time to listen to the resident's concerns or questions on or after June 16, 2017.
[s. 3. (1) 1.] (210) [s. 3. (1) 1.]

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 resident right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity , was fully respected and promoted, to be implemented voluntarily.

WN #2: 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

During stage one of the Resident Quality Inspection (RQI) the falls inspection protocol triggered for resident #003 related to falls. Resident #003 was triggered due to fall incident on an identified date.

Record review of a progress note indicated that resident #003 fell after attempting to get out of their mobility device causing a small abrasion to an identified part of their body. The home completed a post fall assessment, and developed interventions to prevent further falls. The interventions included to keep the call bell within reach, place an alarm

system on resident #003's mobility device and check functionality of the alarm as a safety precautions.

On the identified date, resident #003 was observed in the activity room sitting in their mobility device. The alarming device was affixed to the side of the mobility device but was not functioning.

Inspector #645 immediately contacted the primary PSW #109 and they confirmed that the alarming device was not functioning. They reiterated that the alarming device was attached to the resident to alert staff members when the resident attempts to get out of their mobility device. PSW #109 stated that the plan of care directed staff members to check functionality of the alarming device for safety.

To expand the resident sample, the inspector made further observations on the same unit. On the identified date, inspector observed resident #005 using their mobility device in their room. Resident #005 had an alarming device on their mobility device but it was not functioning. Inspector contacted the primary PSW #110 and they confirmed that the alarming device was not working. They immediately contacted maintenance and the alarm was fixed.

Interview with the DOC confirmed that the plan of care for both residents #003 and #005, directed staff members to check functionality of the alarming device for safety. They reiterated that staff members are expected to provide care as specified in the plan of care, and confirmed that PSWs #109 and #110, did not provide care as specified in the plan. [s. 6. (7)]

2. Record review of a Critical Incident System (CIS) report, submitted to the MOHLTC indicated that resident #001, had a fall on an identified date.

Record review of the progress note for resident #001, revealed that resident #001 had another fall after the identified date mentioned above. A review of the post fall assessment indicated that the resident was found on the floor and the floor-mat and bed alarms were not functioning at the time. A review of the plan of care effective after the second identified fall, directed staff members to frequently check functionality of the alarm system to maintain safety of the resident.

Interview with the DOC confirmed that the plan of care for resident #001 directed staff members to check functionality of the alarming device for safety. The DOC reiterated that

staff members are expected to provide care as specified in the plan of care and they did not check the alarming device for resident #001 as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that when resident #001 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Review of a CIS report submitted to MOHLTC indicated that resident #001 had an unwitnessed fall and injured an identified part of their body on an identified date.

Record review of the progress note indicated that resident also had multiple falls before the unwitnessed fall mentioned above. The resident's plan of care was updated with fall prevention interventions on the identified date after the first fall incident. Further record review indicated that the plan of care was not updated, and no new interventions were implemented after the above mentioned fall incident.

An interview with the DOC and RAI coordinator indicated that when a resident has a fall, registered staff are expected to reassess the resident, develop interventions to prevent further falls and update the plan of care. In the event where the resident continues to fall, staff are to develop different approaches to prevent the fall from happening again and modify the plan of care with new interventions. During the interview the DOC reiterated that recurring falls are the result of unmet or ineffective interventions and requires reassessment to prevent further fall incidents and injuries. During the interview, both the DOC and RAI Coordinator stated that registered staff neither used a different approach, nor implemented different interventions to prevent resident #001 from having recurring falls. [s. 6. (11) (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 care set out in the plan of care was updated and provided to the residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

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 was reported to the licensee was immediately investigated.

A complaint was submitted to the MOHLTC alleging that the home did not respond appropriately when the complainant advocated regarding a concern about how resident #006's finances were dealt with. The complaint was communicated to SW# 101 and #102 verbally and in writing on an identified date.

A review of the home's policy titled Resident/Family Concern/Complaint Resolution, ADM-RS-05 dated February 2011, indicated that upon receipt of a concern the first staff person or volunteer receiving the concern will complete the concern/Complaint/Recommendation Form. If the concern includes an allegation of abuse, (according to policy ADM-INTRO-05 Zero Tolerance of Abuse) as this issue must be investigated immediately and also reported to the MOHLTC immediately.

According to SW #101, the complainant requested clarification about resident's finances related to missing money. SW #101 stated they did not interpret the request as a misuse or misappropriation of the resident's money, therefore they did not take further action.

According to the complainant they submitted a letter to SW #102 stating, that SW #101 did not document the resident's wallet and the contents in it during admission into the LTC home. The complainant received a response on an identified date written by SW #101 and ED #103 was copied on it. The complainant was not happy with the response because they complained about the way SW #101 dealt with the concern and SW #101 was the same one responding to their concern. The complainant expected that someone superior to SW #101 would investigate the complaint and respond to it.

A review of resident #006's clinical record and interview with SW #101 and ED #104 were unable to demonstrate that an investigation was commenced.

Interview with SW #102 indicated they did not realize that the letter received was referring to suspected abuse of resident #006's finances and they did not forward the letter to ED #103.

Interview with present ED #104 acknowledged that suspected financial abuse should have been immediately investigated. They further indicated that when SW #101 learned that resident #006 had a concern about their finances, and SW #102 received the written complaint about suspected financial abuse, they were expected to follow the home's policy, report it to ED #103 who worked at that time and initiate an immediate investigation. [s. 23.] (210) [s. 23.]

WN #4: 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the suspicion and the information about misuse or misappropriation of a resident's money that has occurred or may occurred was immediately reported to the Director.

A complaint was submitted to the MOHLTC alleging that the home did not respond appropriately when the complainant advocated regarding a concern about how resident #006's finances were dealt with. The complaint was communicated to SWs# 101 and #102 verbally and in writing on an identified date.

According to the complainant, they approached SW #101 and requested a verbal clarification regarding the status of their money and continued communicating with the home about financial issues. The complainant then submitted a letter to SW #102 stating the suspicion that resident #006's wallet was not handled properly when the resident was admitted to the home.

Interview with SW #101 indicated that when resident #006's friend approached them to clarify about the missing money on an identified date, they refused the request, because they did not suspect misappropriation of the resident's money.

Interview with SW #102 indicated they did not realize that the letter from the complainant was referring to a suspected financial abuse of resident #006's money, and they did not inform ED #103 about the letter. At that time, the role of the ED was in a transitional phase, ED #103 was in a process of leaving the home and ED #104 was contemplating the role.

A review of the policy Resident/Family Concern/Complaint Resolution, ADM-RS-05 dated February 2011, indicated if the concern includes an allegation of abuse, (according to policy ADM-INTRO-05 Zero Tolerance of Abuse) as this issue must be investigated immediately and also reported to the MOHLTC immediately.

Interview with ED #104 indicated that when SW #101 received the verbal concern related to resident #006's finances, and when SW #102 received the complaint letter regarding improper handling of finances, the expectation was that the home's policy was to be followed and the suspicion reported
to MOHLTC. [s. 24. (1)] (210) [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A CIS report was received by the MOHLTC indicating resident #001 had a fall resulting in injury on an identified date. A record review of the post fall assessment indicated that resident #001 sustained an area of altered skin integrity on an identified area of their body. Review of the progress note did not indicate if a skin assessment was completed using a clinically appropriate tool.

Record review of another CIS report received by the MOHLTC indicated that resident #002, had a fall on an identified date. Further record review indicated that the resident had recurrent falls on multiple occasions. On an identified date, the Head Injury Routine (HIR) document indicated that resident #002 sustained an area of altered skin integrity on an identified part of their body. A review of the progress also indicated that resident #002 had another fall and sustained injury. Further record review indicated that skin assessment was not completed for the above mentioned skin alterations using the home's clinically appropriate tool.

Interviews with RPN #106 and RN #112 revealed that skin assessments should be documented under progress notes and a weekly skin assessment is initiated if resident exhibited altered skin condition.

Interview with the DOC confirmed that skin assessments for both residents #001 and #002 following the above mentioned fall incidents, were not completed using the home's clinically appropriate tool. The DOC reiterated that staff are expected to complete a head to toe assessment and initiate a weekly assessment when residents exhibit altered skin condition. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information (such as the long-term care home's procedure for initiating complaints to the licensee and the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints) were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

A complaint was submitted to MOHLTC indicating a submission of verbal and written complaints to several people in the home such as: SW #101, SW #102, the home's Physician, and the home's general email, about concerns including but not limited to how resident #006's finances were dealt with.

Interview with the complainant indicated they were not aware about the home's procedure for submitting a complaint. The complainant did not notice the same posted in the home.

Observation in the home on an identified date by Inspectors #645 and #210, indicated the MOHLTC info line was posted on the main floor, across from the front desk, and on 4th floor, beside the elevator. The sign on main floor, located on the corner wall across from the front desk, was not easily accessible and visible because there was an information stand with a poster for activities, in front of it.

Interview with ED #104 further indicated that the home created a complaint/concern procedure poster two weeks ago but it was not posted around the home yet. The complaint/concern procedure poster indicated a process for residents, families and visitors to contact the appropriate staff in the home with contact numbers, and how the issue can be escalated if not resolved.

Interview with ED #104 acknowledged that the sign with the MOHLTC info line posted on the main floor was not visible and the home's procedure for initiating complaints was not posted. [s. 79. (1)] [s. 79. (1)]

WN #7: 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. (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 a documented record was kept in the home that includes: the nature of each verbal or written complaint, the date the complaint was received, 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, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

A complaint was submitted to MOHLTC by resident #006's SDM who indicated that they submitted a written complaint on an identified date to SW #102 about resident #006's admission into the long term care home, and how resident #006's finances were handled. Interview with SW #102 indicated they did not document the complaint onto a complaint form to be further logged into the complaint binder log, nor did they communicate with ED #103 about the complaint letter.

Interview with SWs #101 and #102 stated that the written complaint was sent to the general email of the home, and another paper copy was submitted to SW #102. SW #101 received a copy of the email and responded to the concern. SW #101 and SW #102 indicated they did not log the complaint into the complaint binder according to the home's policy.

Interview with the DOC and ED #104 indicated they were not aware of the written complaint mentioned above from resident #006's POA, because it was not logged into the complaint binder.

A review of the complaint binder for 2017 and interview with DOC and ED #104 confirmed no evidence that there was a documented record of the written complaint from resident #006's SDM to the home, including the date of the action, time frames for actions to be taken and any follow-up action required or the final resolution. [s. 101. (2)] (210) [s. 101. (2)]
(210) [s. 101. (2)]

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.