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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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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
Feb 25, 2014	2014_274535_0002	T-764-13	Complaint

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue, Woodbridge, ON, L4L-1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court, Woodbridge, ON, L4L-9T3

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

VERON ASH (535)

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 28, 29, 30, 31, 2014

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered staff, resident assessment instrument (RAI) coordinator, registered nurse champion, assistant director of care (ADOC), director of care (DOC), administrator, maintenance manager, maintenance worker.

During the course of the inspection, the inspector(s) observed residents interaction with staff, 5th floor nursing unit, conducted interviews, reviewed responsive behavior policy and program, resident health records, abuse and neglect policy, staff training records, and home investigation of the incident.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 001 is protected from neglect by staff.

Resident's plan of care indicated that the resident is to be taken to the nursing station when restless identified by grabbing/picking at what she could reach. The interventions identified in the plan of care were to keep the resident away from side-

rails, bring the resident to the nursing station and supervise her at all times.

Health records review indicated and staff interviews confirmed that resident #001 is to be placed at the nursing station for safety observation. Staff stated multiple locations in the vicinity close to and around the nursing station where resident can be placed for safety observation. The plan of care did not provide clear directions for staff in relation to safe placement of the resident. The director of care (DOC) identified three specific locations on the unit where the resident could safely be placed by staff, however, these locations were not included in the resident plan of care.

On Friday, December 20, 2013, at approximately 18:30 hours, resident #001 was placed in the hallway, away from the side-rails, with her back towards the staff locker room door, in front of the nursing station on the 5th floor. The resident was exhibiting her usual identified restless behaviors – both arms out-stretched and grabbing/picking at what she could reach.

At approximately 19:00 hours, an identified registered staff left the nursing station to complete the scheduled medication pass, therefore leaving the resident unattended. Between 19:00 and 19:30 hours, an unidentified staff member entered the staff locker room. Resident # 001 out-stretched right hand and her fingers went toward the opened door. Her right ring finger tip got caught in the middle hinge of the door just as the door closed. The impact of the solid door closure amputated the resident's right ring fingertip. The resident's flesh from her fingertip was stuck in the middle hinge of the door.

An identified PSW, who discovered the resident bleeding, informed the RPN, however, the PSW did not look to see where the resident was bleeding from. The RPN did not inquire about the reason for bleeding and did not assess the resident. The PSW wrapped a towel around the resident's right hand and left the resident unattended to complete her scheduled nourishment duties. Approximately 10-15 minutes later, another PSW observed the resident bleeding and informed the RPN. The RPN assessed the resident and the resident was transferred to the hospital.

Staff interviews confirmed that the resident was left unattended after her fingertip was amputated for approximately 10 to 15 minutes before an assessment was initiated.

A review of staff training record for the prevention of abuse and neglect of residents and behavior management indicated that not all direct care staff completed the

training as required for 2013. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with resident, annual training and retraining at times and intervals provided for in the regulation, in behavior management and the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of staff training record indicated that not all direct care staff completed the training as required for 2013. Interview with the registered nurse champion confirmed that just 71% of all staff received the training in behavior management and 96% of all staff received the training in abuse and neglect of residents in 2013. [s. 76. (7) 3.]

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 all staff who provide direct care to residents receive training in behavior management and the home's policy to promote zero tolerance of abuse and neglect of residents as set out in the regulations, to be implemented voluntarily.

WN #3: 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 licensee failed to ensure that the written plan of care for resident # 001 sets out clear direction to staff and others who provide direct care to the resident.

Health records review indicated and staff interviews confirmed that resident #001 is to be placed at the nursing station for safety observation. Staff stated multiple locations in the vicinity close to and around the nursing station where resident can be placed for safety observation. The plan of care did not provide clear directions for staff in relation to safe placement of the resident. The director of care (DOC) identified three specific locations on the unit where the resident could safely be placed by staff, however, these locations were not included in the resident plan of care. [s. 6. (1) (c)]

2. The licensee failed to ensure the care set out in the plan of care is provided to resident # 001 as specified in the plan.

Health records review indicated and staff interviews confirmed that the resident was left unattended at the nursing station prior to the incident and for approximately 10 - 15 minutes after the incident occurred. The resident plan of care states that resident is not to be left unattended at the nursing station. [s. 6. (7)]

3. The licensee failed to ensure that resident # 001's plan of care was reviewed and revised when the resident's care needs changed.

A review of the resident plan of care revealed and interview with registered staff confirmed that the plan of care was not reviewed and revised when the resident's care needs changed after the incident on December 20, 2013. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that resident # 001's room was maintained in a good state of repair.

On January 28, 2014 the inspector observed resident # 001's room. There was a single bed against the wall, a full-sized, single mattress lying horizontally between the resident bed and the wall. Removal of the mattress revealed an approximately 30 cm x 5 cm x 3 cm in depth area of missing wall covering with dry-wall exposure.
The inspector informed the home's maintenance manager of the disrepair.

On January 31, 2014, the inspector observed the resident's room and the wall was repaired and repainted. [s. 15. (2) (c)]

Issued on this 3rd day of March, 2014

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2014_274535_0002
Log No. / Registre no:	T-764-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 25, 2014
Licensee / Titulaire de permis :	FRIULI LONG TERM CARE 7065 Islington Avenue, Woodbridge, ON, L4L-1V9
LTC Home / Foyer de SLD :	VILLA LEONARDO GAMBIN 40 Friuli Court, Woodbridge, ON, L4L-9T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANNETTE ZUCCARO-VANIN

To FRIULI LONG TERM CARE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that residents are not neglected by staff. The plan should include but not limited to the following:
1) Training for staff in behavior management and the prevention of neglect of residents.
2) Strategies to ensure staff take immediate action to address significant changes in residents' health status.
Please submit the plan to veron.ash@ontario.ca on or before March 10, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that resident # 001 is protected from neglect by staff.

Resident's plan of care indicated that the resident is to be taken to the nursing station when restless identified by grabbing/picking at what she could reach. The interventions identified in the plan of care were to keep the resident away from side-rails, bring the resident to the nursing station and supervise her at all times.

Health records review indicated and staff interviews confirmed that resident #001 is to be placed at the nursing station for safety observation. Staff stated multiple locations in the vicinity close to and around the nursing station where resident can be placed for safety observation. The plan of care did not provide clear directions for staff in relation to safe placement of the resident. The director of care (DOC) identified three specific locations on the unit where the resident could safely be placed by staff, however, these locations were not included in the resident plan of care.

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At approximately 19:00 hours, an identified registered staff left the nursing station to complete the scheduled medication pass, therefore leaving the resident unattended. Between 19:00 and 19:30 hours, an unidentified staff member entered the staff locker room. Resident # 001 out-stretched her right hand and her fingers went toward the opened door. Her right ring finger tip got caught in the middle hinge of the door just as the door closed. The impact of the solid door closure amputated the resident's right ring fingertip. The resident's flesh from her fingertip was stuck in the middle hinge of the door.

An identified PSW, who discovered the resident bleeding, informed the RPN, however, the PSW did not look to see where the resident was bleeding from. The RPN did not inquire about the reason for bleeding and did not assess the resident. The PSW wrapped a towel around the resident's right hand and left the resident unattended to complete her scheduled nourishment duties. Approximately 10-15 minutes later, another PSW observed the resident bleeding and informed the RPN. The RPN assessed the resident and the resident was transferred to the hospital.

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(535)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of February, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Veron Ash

Service Area Office / Bureau régional de services : Toronto Service Area Office