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
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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
Sep 13, 2013	2013_157210_0022	T421-13 AND T 303-13	Complaint

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

FUDGER HOUSE
439 SHERBOURNE STREET, TORONTO, ON, M4X-1K6

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 3, 4, 5, 6, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Nurse (RN), Registered Practical Nurse (RPN), Director of Care (DOC), Unit Manager (UM), Nutrition Manager, Manager of Environmental Services, RAI MDS Lead, Supervisor of Education Services.

During the course of the inspection, the inspector(s) reviewed policies for Zero Tolerance of Abuse and Mandatory Reporting, Prevention and Management of Hot Weather Related Illness, Air Conditioning System inspection and repair report, Air temperature logs, internal incident investigation reports, education and in-services reports, resident's health records.

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

Dignity, Choice and Privacy

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Interview with an identified staff indicates that on an identified date in 2013 during evening care the privacy curtain was not closed when staff provided personal care to Resident #1. Interview with another identified staff indicates that because sometimes the curtain does not work properly staff is not able to close it in order to provide privacy. [s. 3. (1) 8.]

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. (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. (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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of the written plan of care for Resident #2 states resident is at high risk for falls, staff to ensure resident uses appliance or walker appropriately, not to leave resident unattended without safety device wheelchair or walker. The written plan of care in relation to ADL assistance states that resident does not walk in the room or corridor and his primary mode of locomotion is the wheelchair. Interview with PT indicates that the primary mode of locomotion of Resident #2 is the wheelchair. Review of the health record indicates Resident #2 had a fall on an identified date in 2013, in the hallway when walking from dining towards his room. Interview with an identified staff indicates resident uses a walker as a primary mode of locomotion. [s. 6. (1) (c)]

2. The licensee failed to ensure that 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, consistent with and complement each other.

Interview with PT indicates that Resident #1 uses a walker for walking in the room and to participate in the PT program. However this was not documented in the written plan of care. He requires two people assistance for participation in the walking strengthening program, but PT assists resident with one person and a wheelchair for safety. The written plan of care indicates resident is at high risk for falls and he does not walk in the room or corridor. The admission assessment indicates resident requires limited assistance by one person for walking in the room and extensive assistance by one person for walking in the corridor. Interview with a an identified staff indicates that staff supervises resident when walking in hallway with the walker. She was not aware what the PT program for Resident #2 was. [s. 6. (4) (a)]

3. The written plan of care for Resident #1 indicates resident requires assistance by two people when continence care is provided, due to aggression.

Interview with two identified staff indicates that on an identified date in 2013, when continence care was provided, resident received assistance by one staff. [s. 6. (7)]

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, 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 person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Interview with an identified staff reveals that on identified date in 2013 Resident #1 was allegedly physically abused by an identified staff while personal care was provided. The incident was verbally reported to an identified Manager two days later. Interview with the same Manager reveals that the incident was verbally reported to the Unit Manager two days after. The incident was reported to the Director eleven days after the incident happened. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident Report reveals that there was an alleged abuse from staff to resident on an identified date in 2013. Interview with the Unit Manager and review of the internal investigation record indicate that the home became aware of an witnessed incident of abuse two days after it happened. The resident's SDM was notified eleven days after the incident. [s. 97. (1) (b)]

Issued on this 13th day of September, 2013

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