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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2016	2016_356618_0022	030043-16	Resident Quality Inspection

Licensee/Titulaire de permis

UKRAINIAN HOME FOR THE AGED
767 Royal York Rd. TORONTO ON M8Y 2T3

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

IVAN FRANKO HOME
767 Royal York Road TORONTO ON M8Y 2T3

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

CECILIA FULTON (618), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 21, 24, 25, 26, 28 2016

The following Critical Incidents were inspected: C530-000001-16, C530-000003-14, C530-000004-14, C530-000002-15.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Physiotherapist (PT), Activity Department Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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	Legendé 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 has failed to ensure that residents were protected from abuse.

The applicable definition of physical abuse in O. Reg. 79/10 of the Long-Term Care Homes Act is "the use of physical force by anyone other than a resident that causes physical injury or pain".

Interviews with registered staff #105 and staff #100 revealed that on an identified date 2016, they heard screaming coming from resident #006's room.

When staff #105 and #100 arrived at the resident's doorway, they observed the resident's door to be wide open, no privacy curtain drawn, and two PSW's were at the resident's bedside providing care to the resident.

Interview with staff #100 revealed that the PSW #111 was at the head of the resident's bed and was observed to be holding the resident's hands very firmly on the resident's chest and the resident was in distress. Staff #100 revealed that they felt that PSW #111 was applying excessive force and that it was wrong.

Interview with staff #105 revealed that when they entered the room they heard resident #006 saying, "don't squeeze me, don't pressure me". Resident #006 was also observed to have a skin tear which staff #105 believed was new.

Interview with the Administrator revealed that when they became aware of the details of the incident, they felt it was staff to resident physical abuse. [s. 19. (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 residents are protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The home has failed to comply with their policy titled Medication, Narcotics and Controlled Substances, #NM-M-036, dated December 2011.

Bullet nine of this policy states that: "Any discrepancies in the narcotics and controlled substance medication or possible tampering, including blister spots that have been taped, must be reported immediately to the Director of Care and/or the Administrator for investigation".

Observation of the contents of the narcotic/controlled substance drawer on identified home areas, revealed narcotic and controlled substance medication cards where the blisters containing medications were broken and had been taped closed.

Interviews with registered staff #107 and #108 revealed that they had observed this and that these blisters are often found in this condition and that this should be reported to the DOC, but it had not been.

Interview with the DOC revealed that staff should be following the policy and reporting these findings to them and that they had not been doing this. [s. 8. (1) (a)]

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 has failed to ensure that when suspected abuse of a resident occurred that the information was immediately reported to the Director.

Record review and staff interviews revealed that on and identified date in 2016, staff #100 and #105 observed an incident involving resident #006 and PSW #111 which they both felt constituted abuse of the resident.

Interview with the Administrator revealed that when they became aware of the incident, they also felt that the description of the incident constituted abuse.

The incident was reported in a Critical Incident report (CIR) to the Director in June 2016.

Interview with the Administrator revealed that they had waited until the completion of their internal investigation of the incident before making the report to the Director.

The Administrator confirmed that this incident should have been reported immediately and that they had failed to report this incident as required. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that no more than a three-month supply of medications were kept in the home at any time.

During the course of this inspection, the Inspector, registered staff #108 and the DOC made an observation of a medication cart on an identified home area. This observation revealed that a 28 dose medication card of an identified controlled substance had been dispensed for resident #007 on an identified date in June 2016. This medication was prescribed to be used only for a specific purpose.

Record review revealed a physician's order dated on an identified date in June 2016, for this medication to be administered only for a specific purpose.

Review of the medication card and count sheet revealed that none of these medications had been dispensed to the resident as prescribed as the specific purpose for which they were prescribed had not occurred and was not scheduled or expected to occur in the foreseeable future.

Interview with the DOC confirmed that this amount of medication was greater than a three month supply. [s. 124.]

Issued on this 27th day of January, 2017

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

Original report signed by the inspector.