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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2016	2015_324567_0012	025750-15	Complaint

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST SCARBOROUGH ON M1L 1W1

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

SOFIA DASILVA (567)

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): October 27, 28, 2015.

The following two intakes were inspected during this CCF inspection: 025750-15 and 013297-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Manager (RCM), Charge Nurse, Registered Staff, Resident Assistants(RA), family members.

During the course of the inspection, the inspector conducted a tour of the home, made observations of: staff and resident interactions; provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Review of a Ministry of Health and Long-Term Care document revealed that on an identified date in 2015, resident #001 eloped from the home. A search of the unit and grounds was conducted. The resident was found approximately 2 to 3 kilometres from the home and was returned safely.

Review of resident #001's plan of care revealed that the resident had been using a device related to security. Further, the plan of care revealed the resident was allowed a certain range of freedom of movement and his/her whereabouts were to be monitored hourly.

Interview with the RCM and the DOC confirmed that the resident eloped. The resident eloped despite the use of a security device.

Interview with the administrator confirmed the incident was investigated and that the resident eloped. [s. 5.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of a Ministry of Health and Long-Term Care document revealed that on an identified date in September 2015, during the night, resident #001 was heard calling out from his/her room. When the resident assistant went to investigate, he/she found resident #002 in resident #001's room near resident #001 and his/her clothing were not all on. Resident #002 was redirected back to his/her room and resident #001 was assessed by the registered staff. Additional monitoring was initiated on both residents.

Interview with the Charge Nurse revealed that following the incident, the residents were both placed on one to one monitoring to ensure the safety of resident #001.

Review of a specified documentation form for resident #001 revealed the form was not filled in on identified dates in October 2015.

As well, review of a specified documentation form for resident #002 revealed the form was not filled in on the same identified dates in October 2015.

Interview with the DOC confirmed that specified documentation forms for these residents were not completed and that the required monitoring interventions were not documented. [s. 30. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Review of a Ministry of Health and Long-Term Care document revealed that on an identified date in 2015, resident #001 eloped from the home. A search of the unit and grounds was conducted. The resident was found approximately 2 to 3 kilometres from the home and was returned safely. A report was submitted to the Ministry of Health and Long-Term Care four days following the incident.

Interview with RCM confirmed the report was submitted late. [s. 107. (3) 1.]

Issued on this 28th day of January, 2016

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

Original report signed by the inspector.