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 sions de longue durée

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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
May 16, 2016	2016_461552_0011	009416-14	Critical Incident System

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

MARIA FRANCIS-ALLEN (552), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 5th, 6th, 8th, 11th, 12th, 13th, 14th & 15th, 2016

Critical Incident logs #009416-14 and log #029454-15 related to responsive behaviors; log #022233-15 resident to resident inappropriate touching; log # 003493 -13, #031438-15 and #007740-16 allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Manager (RCM). Registered Nurse (RN), Registered Practical Nurse (RPN), Resident Assistant (RA) and residents.

Also observed staff to resident interaction during meal service, reviewed resident clinical health records and the home's policy related to responsive behaviors, complaint process and prevention of abuse

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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	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. 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 the person who had reasonable grounds to suspect abuse of a resident by anyone was immediately reported to the Director.

Regarding log #003493-15

On an identified date RCC # 103 was contacted by the attending physician who indicated resident #017's Substitute Decision Maker (SDM) reported an allegation of staff to resident physical abuse.

The SDM indicated that a staff was observed being physically abusive to the resident.

The Director was notified of the allegations eleven days later. [s. 24. (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 person who has reasonable grounds to suspect abuse of a resident by anyone immediately reports it to the Director, to be implemented voluntarily.

WN #2: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee 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): 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

1. Regarding log #009416-14

A Critical Incident Report (CIR) was submitted by the home on an identified date indicating that six days earlier resident #007 was witnessed by a visitor being physically abusive towards resident #006. The resident was sent out to the hospital and it was determined he/she had sustained an injury.

During an interview with the Director of Care (DOC), she confirmed the incident was not reported to the Director within the time frame indicated in the legislation. The Director was notified of the incident four days later.

2. Regarding log #00864-15

Clinical health records indicate that resident #002 is cognitively impaired and has a history of falls, although he/she has not had a fall for several months. Resident #002 uses a mobility aide and requires one staff to assist with all mobility, transfer and toileting. Resident #002 has a front closing seat belt to prevent falls related to the resident's responsive behaviour.

On an identified date resident #002 complained of pain in a specific area and was assessed by the physician. Later that day, resident #002 was noted to have swelling to that specific area and was transferred to the hospital.

Review of the progress notes for resident #002 indicated the home became aware of the resident's injury on an identified date.

During an interview the DOC and Administrator indicated to inspectors they were aware that reporting to the Director had not taken place according to the legislative time lines.

The incident involving resident #002 was reported to the Director four days after the licensee became aware the resident had sustained an injury.(194)

3. Regarding to log #003212-15

A CIR was received on an identified date for resident #011 who was transferred to hospital due to a fall. The CIR indicated, the resident had sustained an injury.

Review of progress notes for resident #011 indicated, on an identified date, that RA staff witnessed the resident slip from the mobility aide with no injury noted. Later that day, the resident complained of pain, was assessed by physiotherapist and was sent to hospital as per physician's orders.

On an identified date, resident #011's POA contacted the home and left a message regarding the resident's injury.

The Director was notified of the incident when the CIR was submitted two days after the resident's confirmed injury.(570)

4. Regarding log #005576-14

A CIR was received for resident #014 who was transferred to hospital five days earlier due to sustaining an injury following a fall.

The Director was notified of the incident when the CIR was submitted, five days after the resident's confirmed injury. (570)

5. Regarding log #009066-16

A CIR was received on an identified date for resident #005 who was transferred to hospital due to sustaining an injury following a fall.

Review of progress notes for resident #005 indicated an entry, on an identified date, that resident #005's POA was contacted and confirmed the resident had sustained an injury.

The Director was notified of the incident when the CIR was submitted, two days after the resident's confirmed injury. (570) [s. 107. (3) 4.]

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 Director is informed no later than one business day after the occurrence of an incident where an injury in respect of which a person is taken to hospital, 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. (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 resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches had not been considered in the revision of the plan of care

Regarding log #022233-15

A CIR was submitted by the home on an identified date indicating that four days earlier, resident #009 was seen by a staff member demonstrating sexually inappropriate behaviours towards resident #010 who is cognitively impaired. The staff member intervened and redirected resident #010.

Review of progress notes in electronic system indicated the resident had exhibited sexually inappropriate responsive behavior on four different occasions over a two month period.

Review of care plan for a specific month related to inappropriate sexual behavior directs staff as followed:
- distract if possible
- set limits for acceptable behavior
- if cognition allows, explain and explore with resident effects of his/her behavior on other residents and staff

Review of care plan completed three months later contained the same strategies.
The licensee failed to consider different approaches when the strategies in the plan of care were found to be ineffective. [s. 6. (11) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home is immediately forwarded to the Director

Regarding log #007740-16

A CIR was submitted to the Director by the home on an identified date indicating the Administrator received an anonymous letter outlining 2 concerns related to staff to resident interaction. The letter indicated RA #138 was observed being verbally inappropriate towards residents on a specified unit.

Review of the home's documentation indicated that an investigation was completed but the letter of complaint was not sent to the Director.

During an interview with the Administrator she indicated that she is aware that any letters of complaints received by the home concerning the care of a resident should be forwarded to the Director but, this letter was not sent. [s. 22. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of staff to resident physical abuse reported by the SDM was immediately investigated.

Regarding log #003493-15

On an identified date RCC #103 was contacted by the attending physician who indicated resident #017's SDM reported an allegation of staff to resident physical abuse.

An investigation was initiated two days after the home was notified of the allegation. [s. 23. (1) (a)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.