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

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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
Feb 16, 2017	2016_484646_0012	034411-16	Resident Quality Inspection

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

IVY LAM (646), ADAM DICKEY (643), JULIEANN HING (649), TILDA HUI (512)

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): December 19, 20, 21, 22, 23, 28, 29, 30, 2016.

The following inspection was completed concurrently during this Resident Quality Inspection (RQI): Critical Incident Inspection: Log #018809-16, related to staff to resident alleged abuse.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Managers (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assistants (RA), Registered Dietitian (RD), Food Service Supervisor (FSS), General Dietary Staff (GDS), Continence Champion, IPAC manager, Infection Control Practitioner (ICP), Director of Environmental Services, Housekeeping Manager, Housekeeping Aide, Physiotherapist, Activation Programs Manager, Activation Assistant, Pet therapy volunteer, Social Worker, Intake Coordinator, Private Sitters, Family Council Chair, Residents' Council Chair, Substitute Decision-Makers (SDM), and Residents.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
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.

6 WN(s)
3 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. 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident.

During stage one of the RQI resident #007 was identified as having alterations to his/her skin integrity.

A review of resident #007's most current written plan of care indicated that the resident is independent with an identified activity of daily living (ADL), and staff to provide extra

assistance with the ADL as required, as the resident needed reminders for the ADL at an identified interval of time.

Interview with RA #133 revealed that he/she did not turn and reposition resident in bed on seven identified days, as the resident is independent with the identified ADL. Interview with the resident revealed that he/she would accept care at night but only from a female caregiver.

Interview with the DOC confirmed that the written plan of care does not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

This inspection was triggered as a result of stage one staff interview related to resident #006's low BMI.

Review of the nourishment schedule on the snack cart, and the meal plan binder in the servery for resident #006 revealed that the resident was to receive an identified nutritional supplement (ONS) at afternoon and evening snack. Review of resident #006's written plan of care in Point Click Care (PCC) and kardex on Point of Care (POC) revealed that neither the written plan of care nor the kardex included information regarding resident's ONS.

Review of the progress notes on PCC revealed that on an identified date, the registered dietitian (RD) had discontinued the ONS as the resident continued to eat well. Review of email communication sent from the RD to the Food Service Supervisors (FSSs) on the same identified date revealed that resident #006's ONS were to be discontinued. Review of Physician's orders in resident #006's paper chart revealed that on the same identified date revealed that the RD had discontinued the ONS.

Observations of the resident #006 at afternoon snack time revealed that resident did not receive the ONS.

Interview with RA #150 revealed that it was his/her practice to look at the nourishment schedule to find information for each resident's ONS, and the RA further revealed the

resident #006 continued to receive ONS at afternoon and evening snack according to her knowledge and review of the nourishment schedule.

Interview with RA #102 revealed that the resident did not receive any ONS, and that the supplement was discontinued a while ago. Interview with RPN #105 revealed that the resident did not receive oral nutritional supplements, and the further revealed that the information regarding the ONS was not on the kardex.

Interview with General Dietary Staff (GDS) #104 revealed that resident #006 continued to receive the items on the nourishment sheet including the ONS. Interview with FSS #106 revealed that resident #006 should continue to receive ONS, based on the nourishment sheet on the cart and the meal plan binder. FS #106 confirmed that the sheets were up to date. FSS #106 further revealed that the dietary staff would print out nourishment labels and the RAs would deliver the ONS to the resident. The FSS told the inspector that it was the home's process for the FSS to update the changes to the nourishment binder and the meal plan binder based on the RD's summary of changes made, and that the RD will communicate changes to the FSS by email.

Interview with the RD revealed that the resident's ONS were discontinued on the identified date and he/she has sent an email to all the FSS regarding discontinuation of resident's ONS on the same identified date. The RD confirmed that resident #006 should no longer have received the ONS. FSS #106 confirmed that the ONS information was on the meal plan document and nourishment information sheet, but not in resident #006's written plan of care, and the various staff members did not ensure all components of resident #006's plan of care were consistent. [s. 6. (4) (b)]

3. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

This inspection was triggered as a result of stage one staff interview related to resident #005's low BMI.

Review of resident #005's written plan of care on PCC, kardex, the nourishment schedule, and the resident's current medication review chart revealed that the resident should receive a regular diet, of an unmodified diet texture. Review of the resident #005's meal plan from the meal plan binder on the unit servery, and SLP assessment on an identified date revealed the diet plan was for the resident to receive an unmodified diet texture.

Observations on two identified dates at the lunch meal revealed private sitter #151 ordered a meal for resident #005 directly from the dietary staff in the servery, and received a tray directly from the dietary staff. Private sitter #151 then brought the tray to resident #005's room.

Observation of resident #005 on an identified date, and further interview with private sitter #151 revealed that the resident was provided an identified entrée of a modified texture. Observations of the resident on another identified date and further interview with private sitter #151 revealed that the resident had another identified entrée of a modified texture

Interview with private sitter #151 revealed that he/she goes to the servery to see what was available and would order an identified modified texture entrée for the resident, and if the resident does not eat it, he/she would order a different modified texture entrée .The private sitter further revealed that the resident has modified texture foods due to swallowing issues, and that the resident was supposed to be on an identified modified texture diet.

Interview with GDS #101 revealed that resident #005 was to receive regular diet with an unmodified diet texture, but that the GDS #101 had given the resident a modified texture because the resident's sitter asked for it. The GDS further revealed that private sitter #151 usually asks the dietary staff for an identified modified texture for the resident, and the GDS was not sure why the private sitter had requested for a different texture than what was in the meal planner.

Interview with RA #100 revealed that it is the home's process for RAs to order the meals for each resident by table, and it should be the RAs who set up trays for the resident. Interview with RPN #108 revealed that it is the RAs' responsibility to order and to provide food to the residents, and the sitter and family members are not supposed to order food, as the family or sitters may order diets and textures that the resident should not receive and this may pose a risk to the resident. He/she further revealed that resident #005 should have received a regular diet with an unmodified texture, and that he/she has communicated with private sitter #151 regarding the resident's diet to let the staff know if the resident is not able to eat this.

Interview with FSS #106 revealed that it is the home's process for the RAs to order food from the dietary staff, and that sitters and family are not to come to the servery area to

order meals. FSS #106 further revealed that a sign was posted in the servery on each unit that stated "STAFF ONLY: Only Houses of Providence staff may order food" to discourage those who are not staff from ordering food for the residents.

Interview with the RD and FSS #106 confirmed that the resident was supposed to receive an unmodified diet texture as per the resident's written plan of care. FSS #106 further confirmed that the dietary staff should have followed and provided the meal based on what was in the care plan and not what family or the sitter asked. The RD confirmed that the staff should not have allowed the private sitter to order meals directly from the dietary staff. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

During stage one of the RQI resident #005's was identified as having alterations to his/her skin integrity.

A review of resident #005's most current written plan of care revealed that resident should be provided an identified ADL assistance intervention at an identified interval of time.

Review of resident #005's ADL assistance record showed that there was no documentation to indicate the resident was repositioned on 13 identified dates.

Interviews with RA #136 and #110 revealed that the provided the assistance on the identified dates but had forgotten to document their care.

Interviews with RPN #108, RN #132 and lead for the skin and wound program #117 revealed that the ADL assistance documentation should have been completed by the RAs for resident #005 on the above-mentioned days.

The DOC confirmed that resident #005's ADL assistance record on the above mentioned days should have been completed by the RAs. [s. 6. (9)]

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:
1) there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident,
2) the staff and others involved in the different aspects of care of the resident collaborate with each other 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,
3) the care set out in the plan of care is provided to the resident as specified in the plan,
4) the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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 resident #001 was protected from emotional abuse by staff in the home.

A Critical Incident report was submitted to the Ministry of Health & Long Term Care (MOHLTC) on an identified date to report a suspected incident of abuse to resident #001. The resident reported to his/her family member that on an identified day, the resident required an identified ADL assistance, and he/she rang the call bell to be assisted off the toilet. According to the resident, RA #115 came in the identified room, raised his/her voice and shook her his/hand over the resident's and spoke in an abusive manner that caused the resident to feel afraid. The resident informed his/her family member that they feared the staff member would hit them and the behaviour was ongoing from the staff member.

During an interview, the resident recounted the incident as above. The resident is alert and oriented, with an identified CPS score. The Inspector conducted a second interview with the resident and the resident could remember what happened during the identified date of the incident. The resident stated that he/she did not report the incident to any staff at the home, and told his/her family member when the family member came to visit a few days later. The family member then reported the incident to the RCM on an identified date and an investigation was initiated with resulting suspension and counselling for the RA prior to return to duty.

During the interview with RA #115, the RA recalled nothing unusual occurred on the identified date. The RA stated that he/she provided assistance to the resident close to the end of his/her shift and another staff member must have finished up the ADL assistance for the resident. The RA denied having been abusive to the resident and stated that she has never had any problem providing care to the resident. Interview with RN #116 indicated there were no concerns with the ADL assistance on the identified date of the incident.

Review of the personal file of RA #115 indicated the RA was disciplined after the incident related to another resident. The RA was suspended and received re-education.

Interview with the Administrator confirmed that resident #001 was not protected from abuse by RA #115. [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 by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted prior to hiring staff member #117.

The abuse prevention program at the home was reviewed including five of the most recently hired employee's personal files. Review of the file for staff member #117 did not include a criminal check report on the staff prior to starting work on an identified date.

During an interview, the Administrator stated the criminal check report was requested prior to the identified date on which the staff member started work, and the staff and the home was still waiting for the report. Staff started work on the identified date without a valid criminal check report. The Administrator indicated the staff was not providing direct care and should be exempted. [s. 75. (2)]

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 criminal reference checks are conducted before hiring staff and accepting volunteers, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI resident #007 was identified as having alterations to his/her skin integrity.

A review of resident #007's most current written plan of care indicated that resident had an identified alteration to his/her skin integrity.

A record review of resident #007's weekly skin and wound assessments in PCC revealed that no assessments had been completed on three identified dates.

Interviews with RPN #124, RN #109, and lead for the skin and wound program #117 revealed that no skin and wound assessments had been completed on the above-mentioned dates.

DOC confirmed that resident #007 should have been reassessed at least weekly for skin and wound by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

2. During stage one of the RQI resident #005 was identified as having alterations to his/her skin integrity.

A review of resident #005's most current written plan of care indicated that resident had multiple identified alterations to his/her skin integrity at an identified area of the body.

Record review of resident #005's weekly skin and wound assessments in PCC revealed that no assessments had been completed on four identified dates.

Interviews with RPN #108, RN #132, and lead for the skin and wound program #117 revealed that no skin and wound assessments had been completed on the above-mentioned dates.

DOC confirmed that resident #005's should have been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that responses in writing were provided to Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council (RC) meeting minutes for the meeting held on an identified date revealed residents' comments regarding that some residents felt they did not get a choice at meals because the staff think they knew what the resident should eat. Residents felt they did not want to tell the staff what they wanted because the staff would get mad at them. At the next meeting on an identified date, resident #030 said there was draft in an identified residents' area on an identified floor and it was cold in there. The minutes indicated that the Administrator will follow up.

Review of subsequent meeting minutes did not reveal documentation to support any follow up action or if residents have been responded to for both of the above-mentioned concerns. Review of the 2016 Food committee minutes on five identified meeting dates did not reveal any evidence of any follow up actions on the meal choice concerns raised at the above-mentioned RC's meeting.

Interview with the Activation and Programs Manager who was the RC's assistant indicated that the home responds to concerns raised at RC meeting informally, usually right at the meeting and there were no formal written responses on the follow up action taken and the time line. Interview with the Administrator confirmed responses in writing were not provided to Residents' Council within 10 days of receiving Residents' Council advice related to concerns raised at the RC meetings. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the

program.

This infection prevention and control inspection was conducted to inspect on concerns observed during the initial tour of the Home during the RQI.

a) On an identified date, the inspector observed the following items in multiple spa rooms on identified resident units: Nine unlabeled used blue plastic razors and an unlabeled used hairbrush with hair.

Repeated observations on another identified date revealed that the above-mentioned items continued to be stored in the same manner.

Interview with RA #121 revealed that the razors were used to shave the resident, and were for one-time use, and were to be thrown out in the sharps container after they were used. The RA further revealed that the nine razors observed were used and were supposed to be thrown out in the sharps container after being used once, and they were not thrown out.

Interview with the IPAC manager and the Infection Control Practitioner (ICP) #122 revealed the Home's policy and expectation is for residents to store hairbrushes and other personal care items in personal boxes or bags in their rooms for, to prevent transmissions of infections.

Interview with the DOC revealed that that it is the Home's expectation for residents' hair brushes and personal care items to be labeled and kept in each resident's own rooms, and not in the spa room to avoid sharing of these items and for infection prevention and control purposes. The DOC confirmed that the items should not have been stored in the spa room.

b) Observations on an identified date revealed that a Personal Protective Equipment (PPE) cart was outside a resident #007 room with no sign on the resident's door. Repeated observation revealed that the PPE cart continued to be outside without signage on resident #007's door.

Interview with RA #126 revealed that the PPE cart was for resident #007, and that the resident had an identified infection. The RA further revealed that he/she was unsure if the

resident should have a sign on his/her door.

Interview with the IPAC manager and ICP #122 revealed that the Home has contact precaution signs for the identified infection, which are in a specific color, and there is another color for another type of infection. ICP #122 further revealed that resident #007 is on precautions another identified infection different from the one mentioned by RA #126, and that the staff in the home has not contacted the IPAC team if the resident had a second identified infection.

Subsequent observations of resident #007 on the same day revealed that a specific colored sign was posted on the resident's door. ICP #122 revealed this was the sign for the second identified infection mentioned by RA #126, but not the identified infection that the IPAC team was aware of.

Interview with RPN #124 on the same day revealed that resident #007 has the identified infection reported to the IPAC team not the other identified infection, and that there was no isolation precaution sign on the door as the sign may have fallen off. ICP #122 clarified with RPN #124 the new sign posted was the wrong sign for the resident's current identified infection.

Interview with the DOC revealed that it was the Home's expectation for precaution signage to be posted outside residents' rooms if residents are on isolation, as a guide for everyone who visits the resident to use proper PPE. The DOC confirmed that the precaution sign should have been posted for resident #007 according to the Home's Infections Prevention and Control program. [s. 229. (4)]

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.