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

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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
Jun 19, 2017	2017_420643_0009	016443-16, 016871-16	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

ADAM DICKEY (643)

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): May 11, 12, 16, 17, 18, 19, 23, 24, 25, and 26, 2017.

The following Complaint intakes were inspected concurrently during this inspection:
#016871-16 related to resident's rights; and
#016443-16 related to resident's rights, continence care and bowel management, nutrition and hydration and personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Client Services Representative- Billing, Security Guards, Interim Resident Care Managers (IRCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Resident Assistants (RA), family members, Power of Attorneys (POA), and Substitute Decision Makers (SDM).

A Written Notification related to O. Reg. 79/10, s. 8. (1) b, identified in concurrent inspection #2017_420643_0010 (Log #008292-17, #009513-17 and #009465-17) will be issued in this report.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Regulations (O. Reg. 79/10, s. 68 (2)) every licensee shall ensure that the organized program for nutrition and hydration includes the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration.

Review of an identified home policy revealed that registered staff were instructed to ensure that a specified nutrition supplement was checked for expiration, labeled with resident name, date, time and staff initial prior to providing the supplement to the resident.

A compliant was received by the MOHLTC regarding several aspects of the care of resident #012. In an interview with resident #012's substitute decision maker (SDM) he/she stated that resident #012 had been provided with an expired nutritional supplement.

Review of resident #012's health records revealed he/she had identified medical diagnoses and nutrition related disorders.

Review of resident #012's progress notes revealed that on an identified date, it was discovered that the specified supplement being provided to resident #012 had expired six months prior to the above mentioned identified date.

In an interview, RPN #130 stated the registered staff does not typically check the expiration date of the specified supplement, assuming that it is coming from the kitchen and it is good. He/she stated that the specified supplement is delivered by the dietary department to the unit on a weekly basis.

In an interview, RD #145 stated that it is the responsibility of both the dietary department and registered staff to check expiration dates for specified supplements to ensure that residents are provided with a safe supply. RD #145 further stated that it was likely delivered to the facility expired, this identified supplement was not likely to have been

overstocked.

In an interview, RPN #160 stated that it was the responsibility of the registered staff to check expiration dates on specified supplements. RPN #160 further stated that he/she was working on the identified weekend , and had provided the supplement and did not recall checking the expiration date prior to providing it to resident #012.

In an interview, IRCM #117 stated that it was the expectation of the home for registered staff to adhere to the same protocols for administration of medication when administering nutritional supplements including expiration date. IRCM #117 acknowledged that the home's policy had not been complied with.

2. The following evidence related to resident #020 was found under inspection report 2017_420643_0010.

As required by the Regulations (O. Reg. 79/10, s. 48. (1) 1) every licensee shall ensure that an interdisciplinary program for falls prevention and management to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

Review of the home's policy titled "Houses of Providence – Fall Prevention and Management" policy number 45, last revised August 24, 2015, revealed that the registered staff are to assess the environment, before mobilizing, for clues as to objects which may have struck the resident during the fall or caused the fall. Additionally, if there is suspicion or evidence of injury the resident should not be moved until a full head to toe assessment has been conducted and appropriate action determined.

Review of a complaint and CIR revealed that resident #020 had a fall incident on an identified date, while being assisted by a staff member of the home. This incident resulted in resident #020 sustaining identified injuries, requiring medical intervention at a hospital.

Review of resident #020's health records revealed that he/she had identified medical diagnoses. He/she had a history of falls since admission to the home, and had been identified as being at high risk for falls. Additionally, resident #020 exhibited identified responsive behaviours which may have contributed to his/her risk of falling.

In an interview, RA #167 stated that he she had been providing one to one (1:1) monitoring for resident #020 on the above mentioned identified date. RA #167 stated that

he/she was assisting resident #020 when resident #020 fell onto the floor. RA #167 further stated that he/she panicked after resident #020 fell, and picked him/her up off the floor before pulling the call bell.

RPN #132 stated that resident #020 had been transferred into bed by the time that he/she arrived to the room to assess the resident. RPN #132 stated that it was the expectation of the home for staff to not move a resident who has fallen prior to being assessed for injury by registered staff.

In an interview, RN #126 stated that it was the expectation of the home that a resident should not be moved following a fall onto the floor until registered staff could assess the resident. RN #126 further stated that RA staff should call for registered staff to come and assess the resident and not move the resident until the registered staff arrives. RN #126 acknowledged that RA #167 did not comply with the home's policy by picking resident #020 up off the floor before registered staff arrived on the scene to assess the resident for injury. [s. 8. (1) (a),s. 8. (1) (b)]

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 with ensuring that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 received fingernail care including the cutting of fingernails.

Complaints were received by the MOHLTC regarding the care of resident #012 in the home from the resident's family members. The complainant stated that resident #012 was not receiving nail care as appropriate resulting in skin tears.

Observations by the inspector on an identified, at an identified time revealed the nails of resident #12 were not trimmed.

In an interview on the same above mentioned identified date, RA #140 stated that it is the responsibility of the RA to trim resident's nails on shower days. RA #140 further stated that resident #012's nails would not be cut after each shower as they would not always be long enough. RA #140 stated that resident #012's nails were not trimmed that day because RA #140 had another resident to shower.

Observations by the inspector one week later, revealed resident #012's nails did not appear to be trimmed since the observations conducted the week before.

In an interview on the later above mentioned identified date, RPN #130 stated that RA #158 had trimmed resident #012's nails the week before. RPN #130 further stated that he/she noted resident #012's nails were long and had asked RA #140 to trim them.

In an interview on May 18, 2017, RA #158 stated that he/she had assisted resident #012 with showering on an identified date, but had not trimmed his/her nails that day. RA #158 further stated that he/she had also showered resident #012 one week prior, and had trimmed the nails on both of the resident's hands after showering him/her that day.

In an interview, interim resident care manager (RCM) #117 stated that it was the expectation of the home for the RA to trim the resident's nails after showering the resident and as needed. He/she acknowledged that based on the observations and interviews with RA #140 and #158 that resident #012 had not had his/her fingernails cared for as expected by the home. In this case the licensee failed to ensure that resident #012 received nail care. [s. 35. (2)]

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Issued on this 21st day of June, 2017

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

Original report signed by the inspector.