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

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5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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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
Jun 16, 2017	2017_626501_0013	026677-16, 033728-16, 034179-16	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

SUSAN SEMEREDY (501)

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 1, 2, 4, 5, 8, 9, 10, 11, 12, 16, 17, 18, 19, 23, 24, 25, 26, 29, and 30, 2017.

Noncompliance under the LTCH Act, 2007, s. 19(1) and s. 24(1) identified in this inspection is being issued under concurrent Critical Incident Inspection #2017_420643_0008.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assistants (RAs), Chaplain, Activation Assistant, Registered Dietitian, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, complaint and critical incident record logs, staff training records, staff personnel records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
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)**
- **1 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. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (3) The criminal reference check must include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 79/10, s. 215 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

According to subsection 75(2) of the LTCH Act, 2007, a criminal reference check is required before a licensee hires a staff member or accepts a volunteer.

Review of files for four staff members and one volunteer revealed the home failed to ensure that vulnerable sector screens were completed as part of the criminal reference checks. Staff member #178, #179 and #159 were hired before vulnerable sector screenings were completed. Staff member #180 and volunteer #181 were hired and vulnerable sector screenings had not been obtained.

During an interview the Administrator revealed he/she was unaware that volunteers had to be screened prior to being hired. The Administrator told the inspector that since volunteers did not provide direct care, he/she believed a vulnerable sector screen was not required.

The Administrator acknowledged the home did not ensure vulnerable sector screens were completed before the above staff members and volunteer were hired.

Due to the severity of potential for harm potential and the scope being widespread a compliance order is being served. [s. 215. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy titled "Zero Tolerance for Abuse and Neglect" last reviewed March 2016, states staff, volunteers, contractors and affiliated personnel must immediately report any witnessed incident or alleged incident of abuse or neglect to the Resident Care Manager/Director of Resident Care/designate.

Two Critical Incident Reports (CIRs) were submitted to the MOHLTC related to resident to resident abuse. According the CIRs, resident #008 was observed exhibiting an identified responsive behaviour toward resident #007 on an identified date.The staff member removed resident #008 away from resident #007.

During an interview with staff member #110, he/she stated that during an activity, resident #008 was sitting beside resident #007 when resident #008 exhibited an identified responsive behaviour toward resident #007. The staff member removed resident #008 from the area. The staff member stated he/she reported this to Activation Assistant #109 and it was decided that staff member #110 would document the incident in both residents' progress notes. Staff member #110 stated that he/she had not received training in the home's policy to promote zero tolerance of abuse and neglect and had not reported this to any manager of the home.

An interview with Activation Assistant #109 revealed he/she was told about the incident by staff member #110 and both had agreed that staff member #110 would document the incident in both residents' progress notes. The Activation Assistant indicated he/she was aware resident #008 has a history of an identified responsive behaviour and considered the actions of resident #008 to be abuse. The Activation Assistant was aware he/she should have immediately reported this to his/her manager.

Interviews with both the above mentioned staff members revealed they did not report the incident to any manager of the home or the MOHLTC. According to the Administrator, the incident came to their attention during morning report which was two days after the incident. The Administrator confirmed that the above mentioned staff members did not follow the home's policy to immediately report any witnessed incident or alleged incident of abuse or neglect to the Resident Care Manager, Director of Resident Care or designate. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Two Critical Incident Reports (CIRs) were submitted to the MOHLTC related to resident to resident abuse. According the CIRs, resident #008 was observed exhibiting an identified responsive behaviour toward resident #007 on an identified date. The staff member removed resident #008 away from resident #007.

During an interview with staff member #110, he/she stated that during an activity, resident #008 was sitting beside resident #007 when resident #008 exhibited an identified responsive behaviour. The staff member removed resident #008 from the area. The staff member stated he/she reported this to Activation Assistant #109 and it was decided that staff member #110 would document the incident in both residents' progress notes. Staff member #110 stated that he/she had not received training in the home's policy to promote zero tolerance of abuse and neglect and had not reported to this to any manager of the home.

An interview with the Administrator confirmed staff member #110 had not received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing his/her responsibilities.

Review of recently hired staff files revealed Activation Assistant #159 had not received training on the home policy to promote zero tolerance of abuse and neglect prior to performing his/her responsibilities and this was acknowledged by the Administrator. [s. 76. (2) 3.]

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 staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, to be implemented voluntarily.

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.

An interview with resident #007's SDM revealed he/she did not believe the home dealt appropriately with his/her complaints. Review of two emails from the SDM that were sent to the home, revealed resident #007's SDM was upset that staff at the home had suggested he/she hire a private caregiver to help care for his/her mother/father.

An interview with the Administrator revealed he/she received these emails concerning the hiring of a private caregiver and supplied a response to the SDM which included actions taken by the home to prevent this from happening again. The Administrator was unaware that the home had to immediately forward any written complaint that has been received concerning the care of a resident or the operation of the home to the Director and in this above mentioned complaint had failed to do so. [s. 22. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each written complaint.

An interview with resident #007's SDM revealed he/she did not believe the home dealt appropriately with his/her complaints.

Copies of two emails sent in 2017 addressed to the Administrator of the home were provided to the MOHLTC by resident #007's SDM. These emails revealed resident #007's SDM was upset that staff at the home had suggested he/she hire a private caregiver to help care for his/her mother/father.

Review of the home's complaint binder for 2017 did not include any complaints from resident #007's SDM.

An interview with the Administrator revealed he/she did respond to resident #007's SDM in a timely manner but failed to document these emails as complaints. [s. 101. (2)]

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

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_626501_0013
Log No. / Registre no:	026677-16, 033728-16, 034179-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 16, 2017
Licensee / Titulaire de permis :	PROVIDENCE HEALTHCARE 3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1
LTC Home / Foyer de SLD :	PROVIDENCE HEALTHCARE 3276 ST. CLAIR AVENUE EAST, SCARBOROUGH, ON, M1L-1W1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Colucci

To PROVIDENCE HEALTHCARE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 215. (3) The criminal reference check must include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 79/10, s. 215 (3).

Order / Ordre :

The home will ensure that a criminal reference check that includes a vulnerable sector screen is obtained before the hiring of staff members or accepting of volunteers.

Grounds / Motifs :

1. The licensee has failed to ensure that criminal reference checks include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

According to subsection 75(2) of the LTCH Act, 2007, a criminal reference check is required before a licensee hires a staff member or accepts a volunteer.

Review of files for four staff members and one volunteer revealed the home failed to ensure that vulnerable sector screens were completed as part of the criminal reference checks. Staff member #178, #179 and #159 were hired before vulnerable sector screenings were completed. Staff member #180 and volunteer #181 were hired and vulnerable sector screenings had not been obtained.

During an interview the Administrator revealed he/she was unaware that volunteers had to be screened prior to being hired. The Administrator told the inspector that since volunteers did not provide direct care, he/she believed a vulnerable sector screen was not required.

The Administrator acknowledged the home did not ensure vulnerable sector screens were completed before the above staff members and volunteer were hired.

Due to the severity of potential for harm potential and the scope being widespread a compliance order is being served. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Toronto Service Area Office