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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 23, 2018	2017_518645_0026	028009-17	Resident Quality Inspection

Licensee/Titulaire de permis

Providence St. Joseph's and St. Michael's 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

DEREGE GEDA (645), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 8, 11, 12, 13, 14, 15, 20, 21, 22, 2017 and January 3, 4, 5, 8, 9 and 10, 2018.

During this inspection, the following intakes were inspected: Intake# 012120-17, and 019141-17 both related to staff to resident abuse, log# 025086-17 related to resident to resident abuse, and five follow up orders with log#016638-17, 016639-17, 016640-17, 016644-17 and 019203-17.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DRC), Resident Care Manager (RCM), Interim Resident Care Manager (IRCM), Activation Program Manager, registered nursing staff, Resident Assistant (RAs), Residents' Council President, Registered Dietitian (RD), private care givers, Family Council President, family members and residents.

During the course of the inspection the inspectors conducted a tour of the home; observed medication administration, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, training records, Human Resource (employee) documents, meeting minutes for Residents' Council, and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_420643_0008	501
O.Reg 79/10 s. 215. (3)	CO #001	2017_626501_0013	501
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2017_420643_0008	501
O.Reg 79/10 s. 54.	CO #003	2017_420643_0008	501
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2017_420643_0008	645

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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of Critical Incident Report (CIR) submitted to the MOHLTC on identified date, revealed that on the same day, RA #112 witnessed resident #040 patting resident #041's identified part of his/her body. The RA intervened and asked resident #040 to refrain.

Review of resident #040's medical record revealed he/she has a mild cognitive impairment. Resident #040's plan of care states there is a potential problematic manner in which he/she acts which is characterized by inappropriate behaviour.

An interview with RPN #115 revealed he/she documented on the identified date that resident #041 was sitting in the identified room and complained that "he/she rubbed my head and I did not like it" while pointing at resident #040. Review of resident #040's plan of care revealed this incident was not recorded in resident #040's plan of care. An interview with the IRCM #104 indicated that the incident was only reported by resident #041 and was not witnessed so the home focused on assessing resident #040's cognitive status and not initiating immediate interventions for resident #040.

An interview with RA #112 revealed that resident #041 was sitting in his/her wheelchair in the hallway when resident #040 was passing by. According to RA#112 resident #040 stopped in his/her wheelchair and was observed to be rubbing/patting resident #041's part of the body. The RA also indicated that resident#040 has a "thing" for resident #041 as he/she often stops to chat with resident #040 if resident #040 is in his/her room. RA

#112 stated he/she was aware of resident #040's history and that in his/her opinion resident #041 is vulnerable because he/she does not have the capacity to consent and would not know to push anyone away as he/she would think the gestures to be of a friendly nature.

Review of the assessment/progress note for resident #040 on the identified date, revealed the Behaviour Support Outreach Team (BSOT) was referred for the resident's identified behaviours. According to this assessment, there was an incident of inappropriateness years ago and only one incident on that day, and concluded that because the incidents were isolated events there was no evidence that resident #040 has inappropriate behaviours.

During an interview with the Resident Care Manager (RCM), he/she could not explain why the BSOT team was not given information regarding the possibility that resident #040 touched resident #041 on two occasions, but that it was most likely because it was not documented in resident #040's medical record and only in resident #041's record. The RCM admitted that BSOT's assessment may have been quite different if they were aware of both incidents. The RCM also stated that something should have been implemented for resident #040's possible inappropriateness on the identified date.

The Resident Care Manager confirmed the home had not ensured strategies were developed and implemented to respond to resident #040's responsive behaviours especially towards resident #041. [s. 53. (4) (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 to ensure strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #2: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Review of CIR submitted to the MOHLTC on identified date, revealed that on the same day, RA #112 witnessed resident #040 patting resident #041 on his/her identified part of the body. The RA intervened and asked resident #040 to refrain.

Review of resident #041's medical record revealed he/she has a mild cognitive impairment. Resident #041's plan of care states there is a need for monitoring of safety and prevention of abuse related to cognitive loss. Resident #041 pointed towards co-resident and informed staff that "he rubbed my body and I did not like it." Interventions included monitoring resident #041 frequently to ensure that he/she is safe and protected.

An interview with RA #105 revealed he/she was resident #041's primary care giver during the shift but had only recently been transferred to this particular unit and assigned to resident #041. RA #105 stated he/she was kept aware of resident #041's plan of care by receiving daily shift reports and accessing the kardex. Review of resident #041's kardex revealed to monitor the resident frequently to ensure that he/she is protected. When asked by the inspector why RAs needed to monitor resident #041 frequently, RA #105 stated that all residents needed to be monitored for safety and was unaware that there had been incidents regarding resident #040 inappropriately touching resident #041.

An interview with the Resident Care Manager (RCM) revealed that RAs do not have access to the full plan of care on their computers but when they are transferred from another unit the registered staff are to provide orientation which would include going over the plans of care with the RAs. The RCM also indicated that resident #041's kardex should have an explanation regarding why he/she needs to be monitored frequently and who he/she needs protection from.

The RCM confirmed that the home failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it. [s. 6. (8)]

WN #3: 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 the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Administrator revealed the home currently does not have a Residents' Council President and the Council will be holding elections. Interview with the former Residents' Council President revealed the home responds to the Council in writing within 10 days inconsistently.

Review of the Residents' Council Concern/Issues/Suggestion Form from a meeting held on the identified date, revealed residents had concerns. The form indicated that there was a concern that new furniture was needed on the identified floor and there needed to be more follow up on communication regarding residents passing away. The manager for the furniture issue was listed as the Administrator with no action plan listed. The manager for the communication regarding residents passing away was listed as the Activation Programs Manager with an action plan. The form has a column that requests a response be made by both managers by the identified date, but there is no indication when these managers responded to the Residents' Council.

Review of the Residents' Council Concern/Issues/Suggestion Form from a meeting, revealed a resident had requested a snack at an identified time and was told that the kitchen was closed. The manager responsible for responding was listed as the Food Services Manager and there was an action described and a request for a response. There is no indication when the response was given to the Council. The Administrator signed the form as approved.

Interview with the Activation Programs Manager, who is currently the assistant to the Residents' Council, revealed the home usually responds to the Council in the next meeting or if one resident has a concern, the manager would go to the resident directly following the meeting. The Activation Programs Manager acknowledged that the form used by the home to respond to the Residents' Council needed to be revised in order to show a better timeline of when the home responds to their concerns. He/she also confirmed the home has not consistently responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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Issued on this 28th day of January, 2018

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

Original report signed by the inspector.