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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2019	2019_630589_0009	014244-17, 016549-17, 021510-17, 026885-17, 002487-18, 007534-18, 007577-18, 013930-18, 019245-18, 031593-18	Complaint

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

JOANNE ZAHUR (589), ORALDEEN BROWN (698), STELLA NG (507)

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): March 18, 19, 20, 21, 22, 25, 26, 28, 29, April 1, 2, 3, 4, 5, and 8, 2019.

The following intakes were completed during this inspection:
-#031593-18 related to short staffing and care not provided to residents,
-#013930-18 related to medication management and responsive behaviours,
-#0024876-18, #026885-18, #021510-17, #016549-17, and #014244-17 related to responsive behaviours, plan of care, continence care, dining and snack service, funding, medication management, programs and feeding techniques,
-#007534-18 and #01924-18 related to financial abuse, and
-#004855-18 related to change in condition.

Written Notification with a Voluntary Plan of Correction related to LTCHA, 2007, S.O. 2007, C.8, s. 6. (7), identified in this inspection will be issued in inspection report #2019_630589_0010.

Written Notification related to LTCHA, 2007, S.O. 2007, C.8, s, 19 (1), (log #031593-18) identified in this inspection will be issued in inspection report #2019_630589_0010.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Care Manager (RCM), Resident Care Supervisors (RCS), Registered Staff (RN/RPNs), Resident Assistants (RA), Agency RA, Physician, Infection Prevention and Control Practitioner (IPAC-P), Housekeeping Services (HS), Activation Assistant (AA), Private Caregiver (PC), Informatics Specialist (IS), Physiotherapist (PT), Building Services and Security Manager (BSSM), Residents, and Substitute Decison Makers (SDM).

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, meal service, and the provision of care, reviewed health records, the home's internal investigation notes, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Safe and Secure Home
Sufficient Staffing

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

- **1 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	Légende 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. 17. Every licensee of a long-term care home shall ensure that the home meets the staffing and care standards provided for in the regulations. 2007, c. 8, s. 17.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home met the staffing needs and care standards provided for in the regulations.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint indicating

that on an identified date in November 2018, there had not been a resident assistant (RA) working on an identified shift. The complaint also indicated that care had not been provided to 19 residents on an identified resident home area (RHA).

A review of the resident census for the above mentioned date indicated there were 17 residents residing on the identified RHA and a review of the daily scheduling roster indicated an agency resident assistant (RA) was booked for the other RHA and a second agency RA was booked for the identified RHA on a special assignment with resident #013. A review of the point of care screens (POC) for the above noted date indicated that, except for resident #013, the remaining 16 residents had not received any care that shift.

The long term care home (LTCH) consists of four floors with each floor having four resident home areas (RHA) for a total of 16 RHAs. A review of the staffing plan for the LTCH indicated that on the night shift each RHA should have one RA for a total of 16 RAs and two RNs in charge. A review of the LTCH's Registered Nurse Routine Practice Expectations indicated, they are to ensure that all units are staffed, collaborate with the team for staff re-assignments if needed, and also update daily staff assignments.

During an interview, staff #114 stated they had worked on the identified date in November 2018, and had been in charge of two identified RHAs. Staff #114 further stated that on initial rounds they had observed two RAs, on one of the identified RHAs and assumed the RHAs were staffed accordingly. Staff #114 was not aware that one of the RAs they had observed was doing a special assignment with resident #013. Staff #114 also stated they had not spoken to either of these two RAs to confirm their assignments.

A review of email correspondence between staff #107 and staff #109 indicated that staff #110 had called the switchboard operator to inform then they had received a call from staff #127 stating they had not shown up for their shift. The switchboard operator informed staff #110 that this RA's name was not on the schedule.

During an interview, staff #111 acknowledged that staff #114 had not followed the home's staffing process and that the care needs of the residents had not been met. [s. 17.]

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 home met the staffing needs and care standards provided for in the regulations, to be implemented voluntarily.

Issued on this 18th day of April, 2019

[redacted]

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

Original report signed by the inspector.