Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jul 22, 2019	2019_630589_0015	003041-18, 008246-19, 013433-19	Critical Incident System

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), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 3, 4, 5, 8, 9, 10, 12, 15, 16, 17, and 18, 2019.

The following intakes were completed during this inspection:
-log #008246-19 related to compliance order (CO) #001 follow-up under s. 19 (1), and
-log #013433-19/CIS #C554-000026-19 and log #003041-19/CIS #C544-000007-18 related to abuse allegations.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Care Manager (RCM), Resident Care Supervisors (RCSs), Resident Assistants (RAs), Registered Practical Nurses (RPNs), Behavioural Support Lead, and Residents.

During this inspection a review of resident health records, the long term care homes (LTCH) internal investigation notes, LTCHs compliance order actions that included staff education attendance records and education materials and relevant policies and procedures were reviewed, and observations of staff to resident interactions were conducted.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)**

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	2019_630589_0010	589

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote resident #009's right to be treated with courtesy and respect and in a way that fully recognized and respected their dignity.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in February 2018, for an incident of alleged abuse that had occurred the previousd month. The CIS report indicated that resident #009 had reported to staff #102 that staff #101 had walked into their room and spoke in a raised tone of voice at them.

A review of the Long-Term Care Homes (LTCH) internal investigation indicated that staff #101 had been suspended pending the investigation. The internal investigation indicated the staff member had not respected and treated resident #009 with dignity.

A review of resident #009's most recent health record indicated they have a cognitive impairment, however had clear speech and adequate hearing. Resident #009 can also understand when spoken to and be understood when speaking. During a conversation, resident #009 stated to the inspector they had reported this incident to staff #102 as they felt staff #101 had spoken inappropriately towards them. Resident #009 could not recall any further specific details of the above mentioned incident.

During an interview, staff #101 denied they had said the above-mentioned statements to resident #009 however they acknowledged that they spoke in a raised tone of vocie and it could be interpreted as being disrespectful. Staff #101 further acknowledged they reviewed the LTCH's Abuse and Resident Rights policies and had completed education on-line prior to resuming their duties in the LTCH.

Staff #103 acknowledged that staff #101 had not treated resident #009 with courtesy and respect. [s. 3. (1) 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 fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The license failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, should immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director on an identified date in February 2018, for an incident that had occurred in the previous month.

During an interview, staff #102 stated they were aware of the after-hours phone number to report incidents and acknowledged they had not notified the Director immediately.

During an interview, staff #103 stated they had been informed of the above-mentioned incident however they initiated an internal investigation first and then submitted the CIS report, two days later. [s. 24. (1)]

Issued on this 23rd day of July, 2019

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

Original report signed by the inspector.