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
Jul 22, 2019	2019_630589_0016	009284-18	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)

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): July 8, 9, 10, 12, 16, 17, and 18, 2019.

The following intake was inspected:
-log # 009284-18 related to Infection Control Practices, Plan of Care, Falls Prevention, Staff to Resident Neglect, Resident's Bill of Rights and Short Staffing.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Resident Care Manager (RCM), Resident Care Supervisors (RCSs), Physiotherapist (PT), Registered Practical Nurses (RPN), Registered Nurse (RN), Resident Assistants (RAs), Substitute Decision Maker (SDM), and Residents.

During this inspection observations of staff to resident interactions, hand hygiene practices, and staff to resident care were observed, also health records, complaints binder, and any relevant policies and procedures were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure the care set out in the plan of care was provided to resident #007 as specified in the plan.

A complaint was received by the Director regarding multiple care concerns related to resident #001. During a conversation with the complainant, they voiced concerns that not all falls prevention interventions and strategies specific to resident #001 were consistently in place.

Related to non-compliances for resident #001 under O. Reg., r. 49., Falls Prevention and Management, the scope was expanded to include resident #010 and resident #007. This inspection did not indicate any areas of non-compliance with resident #010.

A review of resident #007's health record indicated they were in the Long Term Care Homes (LTCH) Falling Star Program as they were at risk for falls. The health record also indicated the use of specific safety devices were to be in place.

Observations conducted by the inspector indicated the specific safety devices were not in place for resident #007.

During interviews, resident assistants' staff #112 and #121 stated that they are responsible to ensure that specific safety devices are in place and functioning. They both recalled seeing them in place previously, however they now could not identify how long they had not been there. Staff #121 acknowledged they had not been checking each shift that these specific safety devices were in place.

During interviews, staff #105 and staff #100 acknowledged that care set out in the plan of care had not been provided to resident #007 as specified in their plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

A review of resident #001's care plan in use at the time of this inspection indicated they were in the physiotherapy program in which they received physiotherapy sessions three times a week with the assistance of two physiotherapy assistants (PTA). Resident #001 is also in the falling star program as they are at risk for falls. Further review of the health record indicated their specific transfer care needs.

Observations conducted by the inspector indicated resident #001 was transferred using the specific care needs specific to them.

During an interview, staff #121 stated resident is transferred with the use of a mechanical lift on an identified shift for care needs. Staff #121 further stated resident #001 cannot always transfer as identified above, so the mechanical lift is used.

During an interview, staff #122 confirmed that resident #001 is in the physio program and stated their transfer assessment only provides the minimal transfer requirements for resident #001's transferring needs and staff are expected to use their clinical judgement if a resident requires a mechanical lift to transfer safely. Staff #122 further stated that resident #001 can exhibit responsive behaviours and that their transfer status ability can change so staff would use the mechanical lift for safety in transferring. Staff #122 also stated a reassessment of resident #001's transfer status had not been conducted because as mentioned previously, staff are to use their clinical judgment when transferring a resident to determine the mode of transfer to be used. Staff #122 acknowledged that resident #001's transfer interventions and their responses to the interventions are not being documented and that the health record should indicate the need for the use of mechanical lifts for transfers later in the day. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies were readily available to meet the nursing and personal care needs of residents #001 and #008.

Related to non-compliances under O. Reg. 79/10., for resident #001 related to s. 44., the scope was expanded to include resident #010 and resident #008. This inspection did not indicate any areas of non-compliance with resident #008.

A review of resident #010's health record in place at the time of this inspection indicated the use of specific devices as a falls prevention intervention. A review of the falls risk action card located on the inside of their bathroom cupboard also indicated the use of these specific safety devices.

On four dates during this inspection, the inspector observed resident #010 ambulating within their resident home area (RHA) with an altered gait. On an identified date in July 2019, the inspector observed that resident #010 did not have the specific safety devices in place.

During an interview, staff #111 stated there had not been any of the specific safety devices available that morning. Staff #111 further stated they were waiting for the specific

safety devices to be available. In a follow-up conversation, staff #111 stated the specific safety devices had been applied to resident #010 approximately two and half hours later.

During an interview, staff acknowledged they had failed to ensure that supplies were readily available to meet the nursing and personal care need of resident #010. [s. 44.]

2. A review of resident #001's care plan in use at the time of this inspection indicated they were in the falling star program as they were at risk for falls.

Observations conducted by the inspector indicated specific safety devices were not applied during morning care by staff #110. During the observation, staff #106 was also present to assist staff#110 with the transfer and stated there were no specific safety devices available. In a follow-up conversation with staff #106 they stated the specific safety devices had been applied two hours later.

A review of resident #001's progress notes indicated that on three occasions in March, once in April, and once in May 2019, registered staff had documented that the specific safety devices had not been applied.

During an interview, staff #105 acknowledged that even though each resident is to have two pairs of these specific safety devices, the home had failed to ensure that supplies were readily available to meet the nursing and personal needs of resident #001. [s. 44.]

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 supplies, equipment, and devices are readily available to meet the nursing and personal care needs of the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

The licensee has failed to ensure that all devices in the home were kept in good repair.

A review of resident #001's health record in place at the time of this inspection indicated the use of safety equipment as a falls prevention intervention as the resident is at risk for falls as identified by being in the falling star program in the LTCH.

A review of resident #001's progress notes indicated the safety equipment had been initiated on an identified date in January 2018, in silent mode, meaning it did not sound at the site as it would result in resident #001 exhibiting responsive behaviours, but to the LTCHs communication system identified as the vocera. A vocera is a portable device carried by staff and it is the communication system used between themselves and residents.

Observations conducted by the inspector on an identified date in July 2019, during morning care indicated when resident #001 was transferred the safety equipment did not sound to the vocera. Staff #106 who was present, pressed down on the bed after the transfer was completed and the safety equipment did not function properly.

During interviews with staff #108 and #121 they stated it is their responsibility to check that the safety equipment are working during their shift and if they are not in good repair, to report to the charge nurse or the physio department. Staff #121 acknowledged they had not been checking the status of the safety equipment for resident #001. Staff #121 could not identify how long the safety device had not been functioning properly. Staff #108 could also not recall how long the safety equipment had not been functioning properly.

During an interview, staff #122 stated that nursing staff had reported to them that resident #001's safety equipment was not functioning. Staff #122 further stated the LTCH does not have a process in place to check on the status of equipment in use but rather they depend on the nursing staff to report when equipment is not in a good state of repair. Staff #122 stated the specified safety equipemnt required a new battery and acknowledged that resident #001's safety equipment had not been in a good state of repair.

During interviews, staff #100 and #105 acknowledged that the home had failed to ensure that resident #001's safety equipment had not been kept in good repair.
[s. 90. (2) (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 that all equipment, devices assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

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.