Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 22, 2020	2020_840726_0005	002118-20, 002346-20, 002583-20	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

Long-Term Care Home/Foyer de soins de longue durée

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

REBECCA LEUNG (726)

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): March 12-13 and off-site: May 14, 19-22, 25-26, June 1-3, 2020.

The following Critical Incident System intakes were inspected during this inspection:
Log #002118-20 and Log #002346-2 related to prevention of abuse,
Log #002583-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Managers, Physiotherapist , Physicians, Behavioural Support Program Lead, Social Work Counselor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW),caregiver and residents.

During the course of the inspection, the inspectors reviewed residents' health records, home's training records, annual program evaluation, abuse incident analysis, policies and
procedures, and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 48, the licensee was required to ensure that a falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention and Management", published on an identified date, which is part of the licensee's falls prevention and management program.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to an identified altered skin integrity observed on resident #003's identified body area. When resident #003 was assessed by RN #116, the resident reported that they had a fall incident. Physician and family were notified. Resident #003 was transferred to the hospital for assessment and returned with a specified diagnosis and a specified treatment applied to their identified body area.

Review of home's "Falls Prevention and Management Policy" published on an identified date, indicated that one of the purposes of the policy was to identify residents at risk for falls and establish individualized care plan for falls prevention and management. The policy stated that the Falls Risk Assessment was to be completed for the residents in various situations including when there is a significant change in the resident's health status.

Review of an identified assessment for an identified date, indicated that resident #003 had a specified diagnosis with a functional impairment, and an identified problem related to mobility was reported.

Review of resident #003's care plan reviewed prior to the incident, indicated that resident #003 had the potential for falls related to the specified diagnosis. Interventions initiated for falls prevention included: hourly safety check, encourage and remind resident to ask for assistance, and ensure mobility device is near and used. Resident #003 required supervision: oversight help with one-staff assistance to walk in room and in the corridor.

Review of resident #003's electronic clinical records and paper clinical chart with the assistance from RN #115, indicated no fall risk assessment was completed prior to the fall incident other than the one that was completed on admission.

Review of progress note for an identified date written by RN #116, indicated that resident #003 was observed experiencing some difficulty with the identified activities of daily living (ADLs), and required a wheelchair for mobility. A referral was sent to physiotherapy for assessment.

Review of the referral to the physiotherapist for an identified date, indicated that the reason for referral was that resident #003 was experiencing difficulty with the identified ADLs, and identified mobility issues were observed, the resident required a wheelchair for mobility.

Review of physiotherapist's (PT #106) assessment for an identified date, indicated resident #003 was assessed for mobility and use of a transport device for mobility. Resident #003 required one-person and moderate assistance in bed and for all mobilities and transfers, and use of an assistive device to walk around the hallway as tolerated. The resident did not participate in the PT program. The PT indicated that resident #003 might require mobility aid for long distance, the resident might use the transport device for mobility as needed, and the care team would still encourage the resident to use the other assistive device as tolerated.

In an interview, RN #115 who was the charge nurse of the entire building, confirmed that resident #003 had one fall risk assessment completed post initial admission with a specified score which indicated low risk for fall. RN #115 stated that prior to the fall incident, resident #003 was walking with an assistive device with one-person assistance, and the resident was observed with identified mobility issues and was having difficulty

with walking from their room to dining room. The resident was referred to the PT for assessment, and the PT recommended the staff to bring resident to the dining room with a transport device. During the interview, RN #115 reviewed the referral to PT for an identified date initiated by RN #116, and stated that RN #116 should have completed the fall risk assessment for resident #003 at that time, as the referral indicated that resident #003 was observed with the identified mobility issues which might put the resident at increased risk for falls, and therefore would be considered as a significant change in the resident's heath and mobility status.

In the interview, RN #116 stated that prior to the fall incident, they observed resident #003 was walking with the identified mobility issues and requested the PT to provide the resident with a transport device to avoid long distance walking to the dining room. RN #116 acknowledged that they should have completed a fall risk assessment for resident #003 at that time as the resident had a significant change in their health and mobility status due to the identified mobility issues observed, which would put the resident at increased risk for falls.

In an interview, NM #103 acknowledged that the registered staff should have completed the fall risk assessment for resident #003 as per the home's falls prevention policy, when they observed the resident with the identified mobility issues before the fall incident occurred, as it would be considered as a significant change in resident's health and mobility status. [s. 8. (1) (a),s. 8. (1) (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 ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect resident #004 from abuse by resident #001.

Under O. Reg. 79/10, subject to subsection s. 2(1) of the Act, "sexual abuse" means (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS report was submitted to the MLTC related to an allegation of sexual abuse between residents #001 and #004. Review of the CIS report and an identified report indicated that on the date of incident, PSW #114 observed resident #001 touching resident #004 inappropriately. Both residents were separated by the staff immediately. RN #108 reported that resident #004 was unable to remember what happened and appeared to be stable with no concern voiced. Physician and families were notified. RN #116 reported that resident #001's behaviour was not new and had no recollection of the incident. Resident #001 was reminded not to touch any staff or residents. The resident was referred to a clinician for assessment. The staff continued to monitor resident #001 for their behaviours.

Review of an identified assessment, indicated that resident #001 had a specified diagnosis with a functional impairment.

Review of resident #001's care plan reviewed prior to the incident, indicated that resident #001 had a history of inappropriate identified behaviour. Resident #001 was observed touching resident #002 inappropriately.
Interventions were initiated on an identified date. They included:
- continue to reinforce to the resident that the behaviour is not acceptable,
- family to continue to also reinforce that the behaviour is not acceptable,
- avoid allowing the resident to sit in an identified location close to the identified residents,
- encourage the resident to sit in the identified location closer to their room,

- if the resident is in the identified resident home area, monitor their behaviour.

Review of an identified note for an identified date written by RN #116, indicated that the staff observed resident #001 touching another resident inappropriately. The staff told resident #001 that the behaviour was not acceptable. Resident #001 was removed from the identified resident home area. No harm to the recipient was documented.

In an interview, RN #116 stated that on an identified date, a staff reported to them that they saw resident #001 touch resident #002 inappropriately when resident #002 walked pass them inside the identified resident home area. RN #116 was unable to recall if resident #001 had touched any private body area of resident #002. RN #116 stated that resident #001's behaviour was inappropriate because they stretched to touch another resident, and that in itself was inappropriate. RN #116 stated when they went to talk to the resident #002, the resident had no recollection of the incident. RN #116 said they reported the incident to the nurse manager. RN #116 stated that they reminded the PSWs not to allow resident #001 to sit in the identified resident home area unattended. Resident #001 should go to another identified resident home area and stay there. RN #116 said they were aware that resident #001 was able to self-propel or wheeled themself back to the identified resident home area by themself. The staff had to monitor the resident and redirect them back to their room or another identified resident home area if they saw the resident in the identified resident home area.

The inspector then told RN #116 that they observed resident #001 sitting in the identified resident home area on an identified date unsupervised. RN #116 said there were situations that when they started the shifts, they saw resident #001 sitting in the identified resident home area unattended. They believed the PSW on the previous shift must have left the resident in the identified resident home area after the meal time. RN #116 said the intervention was usually effective if the staff followed the plan of care, and in the situation on the identified date, the staff did not follow the plan of care, that was why resident #001 got to touch resident #002 in the identified home area. In regard to the incident that occurred between resident #001 and resident #004 on an identified date, RN #116 stated they remembered someone reported the incident to them, but they could not recall the details of the incident.

Review of clinical note for an identified date written by Behavioural Support Program Lead (BSP) #109, indicated that case consultation using a specified clinical analysis with unit care team was held by the clinician. An identified monitoring was initiated to establish frequency, trend and patterns of responsive behaviors. Recommendations and

considerations to support interventions are to screen for a specified clinical condition as resident may be experiencing mood issues. Staff to use communication cue cards due to language barrier to help staff communicate with resident during care. A specified reassessment was recommended to establish the resident's baseline functioning.

Review of an identified assessment indicated that resident #004 had specified diagnoses with a functional impairment.

Residents #001 and #004 were not interviewable at the time of the inspection.

In an interview, social work counselor #111 stated that resident #004 liked to go and sit at an identified resident home area during a specified time range. After the incident occurred, they were trying to put a monitoring device on resident #004. When the resident went down, the staff would know the resident went into the elevator. However, the problem remained as resident #004 was not supervised when they were waiting at the identified resident home area during the specified time range.

In an interview, PSW #114 stated that at the time of the incident, when they heard resident #004 asking for help, they saw resident #001 touching resident #004 inappropriately. PSW #114 removed resident #001 from resident #004 immediately and redirected resident #001 back to their room. PSW #114 stated that resident #004 was saying to them repeatedly that resident #001 touched them. Resident #004 appeared to be fine and no emotional symptom was observed. PSW #114 said they reported the incident to RN #116, the charge nurse on the main floor. RN #116 then spoke to the PSWs and asked them to keep resident #001 away from the identified resident home area.

In an interview, RN #116 stated that they were unable to recall the details of this incident. They said that before the pandemic started, resident #004 used to go to the identified resident home area during the identified time range. The BSP lead had started the specified monitoring to assess the triggers for resident #001's inappropriate behaviours.

In an interview, RN #108 who was the charge nurse, stated that after the incident occurred, they went to assess resident #004, and resident #004 was unable to remember what happened. RN #108 then spoke with PSW #114 to obtain report regarding the incident. RN #108 stated that they did not observe any emotional symptom on resident #004 after the incident occurred.

In an interview, the attending physician #112 of resident #004 stated that no specified symptom was observed on resident #004 after the incident occurred. Physician #112 confirmed that resident #004 was unable to provide consent for touching of a specified nature.

Review of the email message received from the director of care on an identified date, indicated that after the other incident occurred between resident #001 and resident #004, resident #001 was referred to the BSP lead again. The BSP lead then completed a referral for resident #001 to be assessed by the external behavioural support resources.

In an interview, Nurse Manager #117 who completed the investigation for this incident between residents #001 and #004, acknowledged that the incident would meet the definition of sexual abuse.

The home has failed to protect resident #004 from sexual abuse by resident #001. [s. 19. (1)]

2. The licensee has failed to protect resident #005 from abuse by resident #001.

Please refer to the grounds provided for non-compliance issued under s. 23 (1) (a) (i).

The initial CIS report was submitted to the MLTC regarding an alleged sexual abuse that occurred between residents #001 and #002. Review of the CIS report indicated that on the date of incident, private sitter #101 reported to the staff that resident #001 touched resident #002 in an inappropriate nature by putting their hand under resident #002's clothing. Private sitter #101 intervened by moving resident #001 away and reported the incident to the staff. The staff immediately redirected resident #001 to another resident home area. Resident #002's physician and families were informed. The incident was reported to the police. Resident #002 was assessed and provided with specified support. Interventions were implemented.

The inspector initiated the inspection on an identified date and conducted record reviews. Review of the identified report and clinical note for identified dates written by RPN #105, indicated it was PSW #100 (not the private sitter #101 as indicated in the CIS report) that witnessed the incident occur between resident #001 and resident #002, intervened and reported the incident to RPN #105. The sequence of events and residents involved described was similar to the CIS report.

The inspector conducted staff interviews on an identified date. In an interview, PSW #100 stated they did not witness the incident and they could not recall clearly what private sitter #101 had told them as they asked private sitter #101 to report the incident to RPN #105 directly. PSW #100 stated that they thought the private sitter #101 said the alleged victim was either resident #002 or resident #005. PSW #100 said they believed the alleged victim was resident #005 based on the description provided by the private sitter #101 of where the resident sat and what they were wearing.

In an interview, private sitter #101 stated that on the identified date and time, they saw resident #001 try to put their hand under resident #005's identified clothing. Private sitter #101 said they intervened by removing resident #001 away from resident #005, then reported the incident to RPN #105, PSWs #100 and #102. The inspector requested private sitter #101 to help identify resident #005. Private sitter #101 took the inspector and introduced the inspector to resident #005. The inspector observed resident #005 wearing clothes and sitting in the area previously described by PSW #100. The inspector then spoke with PSW #100 and they helped to confirm the identity of resident #005.

The inspector attempted to greet resident #005 and self-introduced. Resident #005 was not interviewable at the time of the inspection.

The inspector then met with nurse manager (NM) #103 who had completed the investigation for the incident. In the interview, NM #103 stated that during their investigation, they did not interview either private sitter #101 or PSW #100 who were described as the witness of the incident in the CIS report, the related notes and the identified report. NM #103 said that they investigated the incident based on the documentations written by the registered staff. The inspector then shared the information obtained from the above-mentioned interviews with private sitter #101 and PSW #100 that 1) private sitter #101 was the actual witness of the incident, but not PSW#100, and 2) the alleged victim was resident #005, but not resident #002 as confirmed by private sitter #101. The inspector then met with the administrator to share the same information. The administrator agreed to re-investigate the incident to verify the alleged victim of the incident.

Review of the amended CIS report showed that resident #005 was added to the list of residents involved in the incident. The report indicated that the family member of resident #005 was upset about the incident, the error that occurred and the timeframe of the investigation.

Review of an identified note written by NM #103 in resident #005's clinical record, indicated that an identified date, the inspector was made aware during the staff interviews that the involved resident (#002) reported in the CIS report was not the resident who was inappropriately touched by co-resident #001. The home immediately initiated re-investigation of the incident and the investigation was started first with the witness, then with the PSW who were present at the time of the incident. Resident #005 was seen by the physician on an identified date. The resident was stable and no change observed clinically. During this period, resident #005 was safeguarded because interventions and strategies were implemented by the BSO team to prevent co-resident #001 from exhibiting the identified inappropriate behaviours.

Review of identified assessment indicated that resident #005 had a specified diagnosis with a functional impairment.

Review of resident #005's current care plan, no specific focus or intervention was written related to the CIS incident to ensure resident #005 was protected from recurrence of similar abuse incident initiated by resident #001.

Review of resident #001's progress notes and care plan indicated that no heightened monitoring intervention was put in place after the previous CIS incident occurred between residents #001 and #004 until another similar incident occurred between resident #001 and resident #005 three days later.

Review of resident #001's current care plan, under the focus of identified inappropriate behaviour related to resident #001 touching co-residents and staff inappropriately. Interventions were initiated after this CIS incident.

In an interview, RPN #105 said that the management staff had met with them to re-investigate this CIS incident. RPN #105 confirmed that PSW #100 and private sitter #101 had reported to them that resident #005 was inappropriately touched by resident #001 as described in a previous identified report and clinical notes except that the actual alleged victim should have been resident #005, and not resident #002. RPN #105 acknowledged that after receiving the reports from private sitter #101 and PSW #100, they went and assessed resident #002 and documented resident #002 as the alleged victim by mistake in the clinical notes and the identified report. RPN #105 acknowledged that resident #005 was not immediately assessed by the registered staff after the resident was abused by resident #001 on the date of incident. RPN #105 said that they did not think resident #005 would allow anyone to touch their private area, but the

resident could not relay it. RPN #105 stated that private sitter #101 reported that at the time of the incident, they heard resident #005 shout at resident #001, that was how resident #005 got the attention from private sitter #101.

In an interview, the attending physician #113 of resident #005 stated that the resident had a specified clinical problem and did not remember the incident at all, and no clinical symptom was observed on resident #005 after the incident occurred. Physician #113 confirmed that resident #005 was unable to provide consent for touching of an identified nature.

In an interview, NM #103 stated that they initiated the re- investigation of the sexual abuse incident initiated by resident #001 to a co-resident and confirmed that the alleged victim was resident #005, but not resident #002. NM #103 acknowledged that the incident would meet the definition of sexual abuse.

The home has failed to protect resident #005 from sexual abuse by resident #001. [s. 19. (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 ensure residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the witnessed incident of abuse of resident #005 by resident #001, that was reported to the licensee, was immediately investigated.

The initial CIS report was submitted to the MLTC regarding an alleged sexual abuse that occurred between residents #001 and #002. The inspector initiated the inspection on an identified date and conducted record reviews. Review of the identified report and clinical notes written by RPN #105, indicated it was PSW #100 (not the private sitter #101 as indicated in the CIS report) that witnessed the incident that occurred between resident #001 and resident #002, intervened and reported the incident to RPN #105. The sequence of events and residents involved described was similar to the CIS report.

The inspector conducted staff interviews on an identified date. In an interview, PSW #100 stated they did not witness the incident and they could not recall clearly what private sitter #101 had told them as they asked private sitter #101 to report the incident to RPN #105 directly. PSW #100 stated that they thought the private sitter #101 said the alleged victim was either resident #002 or resident #005. PSW #100 said they believed the alleged victim was resident #005 based on the description provided by the private sitter #101 of where the resident sat and what they were wearing.

In an interview, private sitter #101 stated that on the identified date and time in the identified resident home area, they saw resident #001 try to put their hand under resident #005's identified clothing. Private sitter #101 said they intervened by pulling resident

#001 in their wheelchair away from resident #005, then reported the incident to RPN #105, PSWs #100 and #102. The inspector requested private sitter #101 to help identify the resident #005 in the identified resident home area. Private sitter #101 took the inspector to the identified resident home area and introduced the inspector to resident #005. The inspector observed resident #005 wearing clothes and sitting in the area previously described by PSW #100. The inspector then spoke with PSW #100 and they helped to confirm the identity of resident #005.

The inspector attempted to greet resident #005 and self-introduced. Resident #005 was not interviewable at the time of the inspection.

The inspector then met with nurse manager (NM) #103 who had completed the investigation for the incident. In the interview, NM #103 stated that during their investigation, they did not interview either private sitter #101 or PSW #100 who were described as the witness of the incident in the CIS report, the related clinical notes and the identified report. NM #103 said that they investigated the incident based on the documentations written by the registered staff. The inspector then shared the information obtained from the above-mentioned interviews with private sitter #101 and PSW #100 that 1) private sitter #101 was the actual witness of the incident, but not PSW#100, and 2) the alleged victim was resident #005, but not resident #002 as confirmed by private sitter #101. The inspector then met with the administrator to share the same information. The administrator agreed to re-investigate the incident to verify the alleged victim of the incident.

Review of the amended CIS report showed that resident #005 was added to the list of residents involved in the incident. The report indicated that the family member of resident #005 was upset about the incident, the error that occurred and the time frame of the investigation.

Review of an identified note written by NM #103 in resident #005's clinical notes, indicated that on an identified date, the inspector was made aware during the staff interviews that the involved resident (#002) reported in the CIS report was not the resident who was inappropriately touched by the co-resident (#001). The home immediately initiated re-investigation of the incident. Investigation was started first with the witness, then with the PSW who were present at the time of the incident. Resident #005 was seen by the physician. The resident was stable and no change observed clinically. During this period, resident #005 was safeguarded because interventions and strategies were implemented by the BSO team to prevent the co-resident (#001) from

exhibiting the identified inappropriate behaviours.

In an interview, RPN #105 said that the management staff had met with them to re-investigate the CIS incident. RPN #105 confirmed that PSW #100 and private sitter #101 had reported to them that resident #005 was inappropriately touched by resident #001 as described in the previous identified report and clinical notes except that the actual alleged victim should have been resident #005, and not resident #002. RPN #105 acknowledged that after receiving the reports from private sitter #101 and PSW #100, they went and assessed resident #002 by mistake and documented the wrong alleged victim in the clinical notes and the identified report. RPN #105 acknowledged that resident #005 was not immediately assessed by the registered staff after the resident was abused by resident #001 on the date of incident.

In an interview, NM #103 stated that they initiated the re-investigation of the abuse incident on an identified date and confirmed that the alleged victim was resident #005, but not resident #002. NM #103 acknowledged that they had made an error in the initial investigation and the home had failed to immediately investigate the abuse of resident #005 by resident #001 after the incident was reported to RPN #105 by the witness (private sitter #101) and PSW #100 on the date of incident. [s. 23. (1) (a)]

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 ensure every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #003 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the MLTC related to a fall incident involving resident #003. Review of the identified reports and clinical notes written by RPN #107 and RN #116, RPN #107 observed an identified altered skin integrity on resident #003's identified body area. When RPN #107 asked resident #003 what happened, it appeared to the RPN that the resident did not know what happened. Assessment conducted by RPN and treatment provided. Physician was notified and orders received. Pain assessment was completed. Family and charge nurse were notified.

When the PSWs were providing personal care for resident #003 later that same day, they observed resident #003 grimacing. Further assessment performed by RN #116 revealed the identified altered skin integrity in another identified body area accompanied by further grimacing and pain elicited on touch or movement. At this time, resident #003 reported to RN #116 that they fell off the bed earlier in the day. When asked to indicate where it hurt, resident #003 pointed to an identified area. At this time, resident #003 was unable to weight bear and required a wheelchair for mobility. The resident was transferred to the hospital for assessment.

Review of readmission note indicated that resident #003 returned from the hospital with a specified diagnosis and a specified therapeutic device applied on the identified body area.

Review of physiotherapist's (PT) assessment for readmission for an identified date, indicated that resident #003 was started on a therapy program.

Review of an assessment completed prior to this incident, indicated that resident #003 had a specified diagnosis with a functional impairment.

Review of resident #003's care plan reviewed prior to the incident, indicated that resident #003 had the potential for falls related to the specified diagnosis. Interventions initiated for falls prevention included: hourly safety check, encourage and remind resident to ask for assistance, and ensure mobility device is near and used. Resident #003 required supervision: oversight help with one-staff assistance to walk in room and in the corridor.

Review of resident #003's fall history, no fall incident was reported in the past 12 months. No recent fall risk assessment was completed prior to this fall incident.

Review of resident #003's electronic clinical record and paper clinical chart with the assistance from RN #115, indicated no post-fall assessment was completed related to the fall incident reported by resident #003 to RN #116 on the date of incident.

In an interview, RPN #107 stated that on date of incident, after breakfast, resident #003 reported that they had an identified skin integrity. RPN #107 assessed resident #003 together with RN #115 at the nursing station. When they asked resident #003 what happened, the resident did not provide the information. When RPN #107 reassessed resident #003 later, they found the identified skin integrity increased by size and notified the physician and family. RPN #107 stated that at that time, they thought resident #003 might have hit themselves somewhere. They did not think of the identified skin integrity could have resulted from a fall. They passed on the information to the next shift for the staff to continue monitoring the resident. RPN #107 stated that they would have done the post-fall assessment if they knew that resident #003 had a fall.

In an interview, PSW #114 stated that on the identified date and time, they went to change resident #003. When they removed the clothing, they observed swelling on resident #003 and the resident was in pain. PSW #114 stayed with resident #003 while their PSW partner went to report to RN #116. RN #116 went to check resident #003 and asked them what happened. Resident #003 told RN #116 that they had a fall. RN #116 assessed the resident, then notified the physician and family.

In an interview, RN #116 stated that on the date of incident, after receiving report from the PSW, they went to assess resident #003 and the resident reported that they had a fall. RN #116 stated they attempted to assess resident #003, but they could not because

the resident was in a lot of pain. RN #116 acknowledged that they should have completed the full set of post-fall assessment for resident #003 including the head-to-toe assessment, pain assessment, post-fall risk assessment, post- fall huddle and to initiate a referral to the physiotherapist as per the home's policy.

In two separate interviews with the nurse managers (NM) who were involved in the investigation of this fall incident, NM #103 and NM #118 both acknowledged that RN #116 should have completed the post-fall assessment for resident #003 after the resident reported that they had a fall incident. [s. 49. (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 ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 2nd day of July, 2020

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

Original report signed by the inspector.