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
Jun 7, 2019	2019_766500_0015	003747-19	Critical Incident System

Licensee/Titulaire de permis

Ukrainian Home for the Aged
767 Royal York Rd. TORONTO ON M8Y 2T3

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

Ivan Franko Home (Etobicoke)
767 Royal York Road TORONTO ON M8Y 2T3

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

NITAL SHETH (500)

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): June 3, 4, 5, 2019.

The intake log #003747-19 (C530-000001-19) related to fall resulted into an injury was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, acting Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed residents' care area, and reviewed residents' and home's records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 :

1. The licensee has failed to ensure that the care set out in the plan of care to keep a specified fall prevention and management device on, when resident #001 was in the bed was provided as specified in their plan.

A review of Critical Incident System (CIS) report indicated that resident #001 had a fall on an identified day. PSW #101 identified the resident was found in a hallway, holding the wall rail, and landed on the floor. The PSW did not have enough time to take action. As per the PSW, there was no alert from a specified device. Upon assessment, the registered staff identified the resident with an injury. The resident was sent to the hospital for further assessment.

A review of the resident's care plan indicated that the resident was at high risk for falls. Interventions included a specified device to be in place and staff to ensure that the device is in working condition.

A review of progress notes indicated that at the time of the fall, the resident's specified device was not turned on. The home conducted an investigation, and the identified shift PSW indicated that the specified device was turned on and in working condition.

Interview with PSW #101 indicated that they observed the resident falling on the floor, however could not react quickly enough to protect the resident. The specified device was turned off at the time of the fall, and it should be turned on all the time.

Interview with RPN #102, and RN #103 (acting DOC at the time of the interview) indicated that they assessed the resident and they were sent to the hospital. During the home's investigation, it was identified that the specified device was in working condition on an identified shift, however at the time of the fall, the specified device was turned off. Acting DOC acknowledged that the specified device should be turned on all the time and in working condition. RPN #102 and Acting DOC indicated that if the specified device was turned on, the staff would have alerted and attended the resident, and the fall might have been prevented.

This non-compliance is issued as the resident had a specified device turned off at the time of the fall incident. Upon observations, the inspector identified that the home had specified device, which had a small sliding on/off switch, and the pad is kept hanging towards the floor, which makes it difficult for the resident to play with it. [s. 6. (7)]

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.