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
Aug 13, 2020	2020_631210_0009	003421-20, 003423-20, 005633-20, 007063-20, 013112-20, 013142-20, 013995-20, 014125-20	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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

SLAVICA VUCKO (210), IANA MOLOGUINA (763)

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 22, 23, 24, 27, 28, 29, 30, August 4 and 5, 2020.

During the course of the inspection, the following Critical incident System (CIS) report intake logs were inspected:

-Log #003421-20, 003423-20, 005633-20, 013112-20, 014125-20 related to falls management program,
-Log #007063-20 related to skin and wound management program and personal support services,
-Log #013142-20 related to change in health status and
-Log #013995-20 related to medication administration.

This inspection was performed concurrently with complaint intakes: Log #008475-20 and Log #010300-20, (inspection report #2020_631210_0008) related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Manager of Resident Services, Registered Dietician (RD), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Personal Support Workers (PSWs) and family members.

The inspector performed observations of staff and resident interactions, provisions of care, reviewed residents' clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

The Ministry of Long term care (MLTC) received a Critical Incident System (CIS) report regarding a fall incident on a specified date, involving resident #004 which resulted in transfer to hospital; resident #004 sustained a body injury and underwent a treatment. The CIS report indicated that PSW #114 failed to apply a specific device after assisting them with care, resulting in the resident sustaining an injury when they fell.

Record review indicated resident #004 was at high risk for falls with cognitive impairment. Resident #004 had not had recent falls. Resident tended to perform activities of daily living independently prior to the fall, and was easily redirected. Interventions in the plan of care to manage resident #004's falls risk at the time of the fall included ensuring resident #004 wore a specific device at all times.

During interview, PSW #114 confirmed that resident #004 was at risk of falls and that they required the specific device to be worn at all times to prevent injuries from falls. PSW #114 stated that on the specified date, they provided personal care to resident #004 and settled them into bed. Another resident required PSW #114's assistance, so PSW #114 left resident #004 in their room without putting the device on the resident. By the time PSW #114 was finished helping the other resident, resident #004 was found on

the floor with injury.

During interview, NM #115 confirmed that the plan of care was not followed for resident #004 after the personal care was provided. NM #115 indicated that prior to leaving a resident in their room unattended, staff were to ensure that residents were left in a safe environment before attending to other residents. [s. 6. (7)]

2. The licensee failed to ensure that resident #005's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The MLTC received a CIS report regarding a fall incident on a specified date, involving resident #005 which resulted in transfer to hospital. The CIS report indicated that resident #005 sustained an injury which was treated in hospital.

Record review and plan of care indicated resident #005 was at high risk for falls related to their cognitive impairment and their inability to recognize their limitations. Resident #005 had a history of previous falls. They required staff assistance with transfers and mobilization around the unit. Interventions in the plan of care to manage resident #005’s falls risk at the time of the fall included a specific device to be utilized when the resident was in bed. A bed and chair alarm were added as additional interventions after the fall to manage resident #005's falls risk when they returned from hospital.

During interview, PSW #116 confirmed that they discovered resident #005 on the floor in their room on a specified date. PSW #116 confirmed that specific devices were present by the resident's bedside at the time of the fall, and that a bed and chair alarm were implemented after the fall.

During interview, RPN #118 indicated resident #005 was at risk of falls because of unsteady gait. RPN #118 confirmed they responded to the fall incident on a specified date and thought that resident #005 tried to self-transfer from their bed to the wheelchair. RPN #118 believed that the device placed beside the bed was a tripping hazard for them, because resident #005 was capable of getting in and out of the bed on their own and had unsteady gait, and used a wheelchair for mobility. Although resident #005 required staff assistance for transfers, they often did not call for help and self-transferred frequently. RPN #118 indicated that there was no reassessment by the staff for whether the specific device were a tripping hazard for the resident prior to the fall, therefore this intervention continued to be in place at the time of the fall.

During interview, RN #117 indicated that resident #005 was closely monitored for falls. RN #117 confirmed that resident #005 had a specific device as a falls intervention during the fall. RN #117 requested for a bed and chair alarm to be implemented after the fall. RN #117 stated that a bed alarm was implemented after the fall to ensure staff would be alerted to resident self-transferring as they did this often without asking for staff assistance. RN #117 stated that if they had a bed alarm on at the time of the fall, staff may have heard resident #005 attempting to self-transfer prior to falling, and may have been able to prevent the fall from happening. They indicated that the specific device in resident #005's room were a tripping hazard and could have contributed to their fall on the specified date. The staff indicated that staff were responsible to revise the resident's plan of care when the resident's care needs changed or care set out in the plan was no longer necessary, and if needed, to involve the home's physiotherapist if a reassessment of the resident's falls prevention interventions were required. RN #117 confirmed that this did not occur for resident #005.

During interview, NM #115 stated that resident #005's often tried to get up from their bed or wheelchair without asking for staff assistance, and they may have been doing that at the time of the identified fall. They also indicated that a bed alarm was not an intervention used at the time of the fall but may have prevented the fall if it was used. NM #115 indicated that staff were responsible to revise the resident's plan of care when the resident's care needs changed or care set out in the plan was no longer necessary; and if needed, to involve the home's physiotherapist (PT) if a reassessment of the resident's falls prevention interventions were required. NM #115 confirmed that this did not occur for resident #005. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective.

The MLTC received a CIS report regarding a fall incident on a specified date, involving resident #003 which resulted in transfer to hospital. The CIS report indicated that resident #003 sustained a body injury for which they required a treatment.

A review of resident #003’s plan of care indicated the resident required one person assistance for transfer and personal care. According to Minimal Data Set (MDS) assessment on a specified date, they were not able to stand on their own.

A review of the clinical record indicated on a specified date and time resident #003 fell on

the floor, when PSW #103 was providing personal care alone. The resident was standing and holding the supporting rail with one hand, and unexpectedly fell on the floor. Interview with PSW #103 indicated they were not able to prevent the resident from falling. The resident sustained injury and was transferred to hospital for further assessment.

A review of resident #003's falls history indicated the resident was at risk for falls and fell previously on a specified date, while RN #108 was assisting with transfer. According to RN #108's post fall assessment, the resident did not sustain injury. Interview with RN #108 indicated they sent a referral to the Physiotherapist (PT) for a transfer assessment.

A review of the PT's post fall assessment on a specified date after the initial fall, indicated resident #003 was able to self-propel in the wheelchair and was assessed for pain in a specific body part. Interview with PT indicated the level of pain did not affect the resident's mobility. They indicated that on a specified date they observed resident #003 for activities of daily living and their documentation was not based on an actual assessment for transfer, but only an observation. The PT indicated when they were supposed to assess resident #003 for transfer, the unit was in COVID-19 outbreak, the resident was COVID-19 positive and the physiotherapy department was providing only urgent services.

According to the interview with the Manager of Resident Services #109, during the home's COVID-19 outbreak the physiotherapy department was supposed to perform urgent assessments only, such as post fall and transfer assessments.

A review of the clinical record and interviews with RN #108, RN #104 and NM #112 indicated that when resident #003 fell on a specified date, and referral was sent to PT for transfer assessment, the resident was not assessed if the current interventions to prevent falls were effective. [s. 6. (10) (c)]

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 care set out in the plan of care was provided to the resident as specified in the plan, the resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary, and that the resident was reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 14th day of August, 2020

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

Original report signed by the inspector.