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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2019	2019_631210_0010	003332-19	Critical Incident System

Licensee/Titulaire de permis

Labdara Foundation
5 Resurrection Road ETOBICOKE ON M9A 5G1

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

Labdara Lithuanian Nursing Home
5 Resurrection Road ETOBICOKE ON M9A 5G1

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

SLAVICA VUCKO (210)

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 10, 11, and 12, 2019.

- Log #003332-19, CIS related to incident with injury, hospital transfer and significant change in status.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Physiotherapist (PT), Program Manager (PM), and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed clinical records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licence failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective and different approaches have been considered in the revision of the plan of care.

A Critical Incident System (CIS) report was submitted to Ministry of Health and Long Term Care (MOHLTC) related to an injury to resident #001 for which the resident was taken to hospital on a specified date, and resulted in a significant change in the resident's health status.

A review of resident #001's clinical record indicated that on a specified date and time the resident was found sitting on the floor in their room by PSW #100 and leaning with their back towards the entrance door. They were transferred to hospital because of pain symptoms for further assessment and diagnosed with an identified injury. When the resident returned to the home they were not able to walk because of a change in condition. The hospital discharge report recommended that a specified medication that could lead to a risk for falls to be discontinued.

A review of the written plan of care for falls indicated numerous interventions for fall prevention but there is no mention of a specified fall prevention and management equipment.

A review of the Falls Prevention Policy #4.1.12, reviewed January 2019, indicated that the interdisciplinary team will consider the use of two specified fall prevention and management equipments to reduce fractures.

Review of resident #001's clinical record indicated the resident was admitted on a specified date with a history of falls. The falls risk assessment indicated the resident was at an identified risk for falls.

The falls history indicated the resident fell seven times since admission during different circumstances such as: activities, in front of their room, in front of the nursing station, from the bed, from the wheelchair, and in the TV room.

Interview with the Physiotherapist (PT) indicated resident #001 participated in the physiotherapy program and was recovering well however they were still at an identified risk for falls.

Interview with Registered Nurse (RN) #102 indicated that after the fourth fall, the care plan was updated with implementing an identified care activity during day and evening shifts, the Behavioural Support Ontario (BSO) team was involved in engaging the resident in activities and one medication was discontinued as per the hospital's recommendation. RN #102 indicated the home holds quarterly falls committee meetings, but the use of the specified fall prevention and management equipment mentioned above has never been discussed. The RN explained that the home considered the current interventions effective because the resident was not falling as frequently as before.

Interviews with the DOC, PT, RN #102, RN #106, PSWs #103 and #104 indicated they did not consider application of the above mentioned fall prevention and management equipment for resident #001 after the seven falls in order to reduce fractures. The DOC indicated that the identified equipment was available in the facility but no practice to implement them on residents. Interview with the PT indicated that they do not recommend the identified equipment because they consider that the physiotherapy program is sufficient for falls reduction, even though the residents are still at high risk for falls after they complete the physiotherapy program. The PT confirmed that they have never recommended the above mentioned fall prevention and management equipment to reduce fractures.

During interviews with the above mentioned staff they were not able to explain why the home did not consider different approaches such as the identified equipment as per the home's policy, when resident #001's written plan of care was reviewed, the resident was at an identified risk for falls, and had previous history of fractures and ongoing falls.

Issued on this 18th day of June, 2019

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

Original report signed by the inspector.