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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
May 22, 2020	2020_643111_0009	022003-19, 022371-19, 003767-20	Critical Incident System

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

LYNDA BROWN (111)

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 9 and 10, 2020.

The following critical incidents were inspected concurrently during this inspection:
-Log # 022003-19 (CIR) related to fall with an injury.
-Log # 003767-20 (CIR) related to a written complaint.

In addition, a follow up inspection was completed related to abuse was also completed.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT) and residents.

During the course of the inspection, the inspector reviewed resident health records, observed residents and resident rooms, reviewed complaints and investigation and reviewed the Fall Prevention program policy.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_823653_0026	111

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 that the care set out in the plan of care provided to the resident as specified in the plan.

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall that resulted in an injury for which the resident was transferred to hospital. The CIR indicated resident #004 had sustained an unwitnessed fall. The CIR indicated the resident complained of pain, was transferred to hospital and was diagnosed with a specified injury. The CIR indicated upon the resident's return from hospital, the resident was to have specified fall prevention interventions put in place.

Review of the progress notes for resident #004 indicated on a specified date, after the resident returned from the hospital (post fall), the PT completed an assessment of the resident and recommended specified fall prevention interventions. The recommendations were communicated to the nursing staff. On a specified date and time, the resident sustained another fall with an injury to a specified area. The PT assessed the resident, indicated the resident was at risk for falls, confirmed the resident did not have specified fall prevention interventions in place at the time of the fall and recommended the same specified fall preventions interventions.

Observation of resident #004 and the resident's room, by the Inspector on a specified date, at various times, indicated the resident did not have specified fall prevention interventions in place.

During an interview with PSW #102, they indicated they were familiar with resident #004 and provided care to the resident. The PSW indicated resident #004 was at risk for falls, due to history of falls and identified specified fall prevention interventions that were to be in place. The PSW was not aware of a specified fall prevention intervention. The PSW

could not indicate why they did not implement a specified fall prevention intervention.

During an interview with RPN #101, they indicated they were familiar with resident #004, the resident was at risk for falls due to previous falls with injury and was to have specified fall prevention interventions in place. The RPN was not aware that specified fall prevention interventions were not in place.

During an interview with the PT, they indicated they assessed all residents post fall, when they received a post-fall referral and they provided recommendations for fall prevention. The PT indicated they documented their assessments and recommendations on the resident's progress notes and communicated them to the nursing staff. The PT indicated resident #004 was at risk for falls and they recommended specified fall prevention interventions.

During an interview with the DOC, they indicated the home had specified falls preventions equipment readily available in the home. They DOC indicated resident #004 was at risk for falls due to history of falls with injury and physical limitations. The DOC indicated the expectation was that all nursing staff were to ensure the falls prevention interventions for resident #004 in the resident's plan of care, were put in place.

The licensee failed to ensure that the care set out in the plan of care for resident #004 related to falls prevention equipment, was provided to the resident as specified in the plan.

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 for resident's related to falls prevention is provided to the resident's as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Review of the home's Fall Prevention and Management policy indicated falls are to be reported to the falls prevention committee for review and advice on interventions. All falls and interventions are reviewed quarterly at the fall prevention and management meeting. The program is to be evaluated annually and updated in accordance with evidence-based practices. The evaluation is documented using the annual program evaluation form.

During an interview, RN #107 indicated they were the chair for the falls prevention committee and the committee consisted of the PT and OT. The RN indicated they met quarterly to discuss residents who have fallen and does not document the meetings. The RN was unable to indicate the date of the last meeting. The RN indicated they review all residents who have fallen to ensure the care plan was updated with falls interventions based on the recommendations by the PT and that the interventions were implemented. The RN indicated they complete a monthly report for the management to identify the falls that have occurred. The RN confirmed the home had specified falls prevention equipment readily available in the home. The RN indicated awareness of resident #004 sustaining a fall on a specified date (CIR), but was not aware of the resident sustaining any other falls. The RN was not aware that specified falls prevention equipment had not

been implemented for resident #004 post fall.

During an interview with the PT, they indicated the home had a falls prevention committee that included, the DOC, RN #107, RPN and the OT. The PT indicated awareness of one quarterly meeting in 2019 and one meeting in 2020. The PT indicated that RN #107 kept minutes of the meetings. The PT indicated the meetings included discussing the previous months falls, reviewing the strategies implemented to prevent falls/injury to determine if they were effective and discuss any other interventions to be used. The PT indicated resident #004 had sustained a fall with an injury on a specified date, they assessed the resident and provided specified recommendations for falls prevention in the residents progress. The PT indicated the resident sustained a second fall and specified interventions were not in place at the time of the fall.

During an interview with the DOC, they indicated the home did not have a falls prevention committee in place, was in the process of setting up a committee and had just met with the PT and RN #107 regarding the committee. The DOC indicated RN #107 had just been assigned as the chair for the falls prevention committee.

During an interview with the ED, they confirmed the home did not yet have a falls prevention committee in place and the DOC was in the process of starting the committee. The ED also confirmed the program had not been evaluated or updated since 2015, as per the policy.

The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

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 there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A critical incident report (CIR) was submitted to the Director for a fall of resident #004 that occurred, that resulted in transfer to hospital and an injury to a specified area.

During a interview with the DOC, they indicated the practice in the home was that after a resident sustained a fall, a post fall assessment was to be completed using the post fall assessment tool on Point Click Care (PCC), under assessments.

Review of the progress notes for resident #004 indicated on a specified date, the resident sustained a second fall and review of the assessments on PCC for resident #004, had no documented evidence of a post fall assessment tool completed.

The licensee had failed to ensure that when resident #004 sustained a fall, the resident had been assessed and a post-fall assessment had been conducted, using the clinically appropriate assessment instrument that was specifically designed for falls.

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Issued on this 1st day of June, 2020

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

Original report signed by the inspector.