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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2018	2018_524500_0012	018626-17, 026493-17, 014186-18	Critical Incident System

Licensee/Titulaire de permis

848357 Ontario Inc.
33 Christie Street TORONTO ON M6G 3B1

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

The O'Neill Centre
33 Christie Street TORONTO ON M6G 3B1

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): July 17, 18, 19, 20, 23, 24, off-site July 26, 2018.

The following Critical Incident System (CIS) intake logs were inspected concurrently during this inspection: #026493-17 (CIS report #2631-000022-17), and #018626-17 (CIS report #2631-000018-17).

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Physiotherapist (PT), Nurse Managers (NMs), Registered Nurse (RN), Registered Practical Nurses (RPNs), Program Therapist, and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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)**

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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee has failed to ensure there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

A review of the Critical Incident System (CIS) report, indicated that on an identified day, resident #001 was found on the floor in their room. Upon asking, the resident reported that they were standing and did not know what happened. The resident was lifted from the floor by staff, and assessment was completed. The resident complained of severe pain and found with a change in the condition. The resident had a diagnosis of a specified health condition and had exhibited some symptoms related to the specified condition in the morning. The resident had a fall in the previous year, and the Substitute Decision Maker (SDM) indicated that the resident had a specified condition and will exhibits certain symptoms related to the specified health condition. The resident was diagnosed with a specified health condition and since then receiving a treatment a year prior to the above mentioned incident happened. The Physician assessed the resident and determine the type of the specified health condition 11 days prior to when the incident happened.

A review of the resident's written plan of care indicated that a care plan and kardex

related to the specified health condition was first initiated on the day when the above incident occurred. The resident however was diagnosed with the specified health condition from a year before, and was receiving a medication treatment.

During the inspection, upon request by the Inspector, the home provided the resident's manual chart. The Inspector identified few copies of a document in the manual chart, indicating about the resident's specified health condition, with directions for staff to follow. The document was not dated and during interviews, staff did not recognize this document or if they have ever seen this document either in the resident's chart or posted somewhere at the nursing station.

Interview with Nurse Manager #108 confirmed that when the incident occurred, it was identified that the plan of care for the specified health condition was not developed and they should have developed it at the same time. The Nurse Manager #108 confirmed that the plan of care should have been added to the kardex for PSWs in order to give clear directions in order to manage the resident during a time when the resident exhibits symptoms of the specified health condition.

Interview with Personal Support Workers (PSWs) #101, #103, #104, Program Therapist #100, RPN #106, RN #106, Nurse Manager #105, PT, and the DOC confirmed that the care plan and kardex related to the specified health condition should have developed prior to the fall incident and when the resident was first diagnosed. They also confirmed that due to episodes of the specified health condition, the resident was at increased risk for the falls. Staff should have clear directions in order to manage the resident during a time when the resident exhibits symptoms of the specified health condition. [s. 6. (1)]

2. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

A review of the CIS report indicated that resident #003 was found sitting on the floor, beside their bed on an identified day. Few minutes later, the resident was noted to having change in the health condition. The resident was transferred to the hospital. The resident was admitted and passed away at the hospital with an identified cause.

A review of resident #003's written plan of care indicated that the resident required assistance for the physical process of toileting related to decreased strength and

balance. Staff to provide limited, one person physical assistance and to adjust clothing, wash hands and perineum care. The resident was frequently incontinence for bladder and staff to toilet the resident upon request. The resident was at risk for falls and staff are to pin the call bell to gown when the resident was in the bed. Staff also to reinforce a need to call for assistance, ensure the environment is free from clutter, ensure washroom floor is clean and dry, and have commonly used articles within easy reach and ensures the resident wears proper footwear.

A review of the resident's progress notes indicated that the resident had falls while trying to use a washroom on five identified days and the interventions were to reinforce and remind the resident to use a call bell when required to use a washroom. The inspector did not find any notes related to staff re-assessing the resident's continence status after the resident had five falls while trying to use the washroom.

Interviews with PSW #101 indicated that they had never seen the resident using a call bell, however if the resident had a toileting schedule established, the home could have prevented some of those falls. PSW #101 confirmed that current use of strategies in order to prevent falls were not effective.

Interview with RPN #102 indicated that the resident would forget to use a call bell, and was incontinent sometimes and the strategies on the care plan was not effective as the resident had multiple falls while attempting to use a washroom. If the resident had a toileting schedule, they could have prevented some of those falls. RPN #102 indicated that the plan of care should have been reviewed and revised when current use of strategies were not effective.

A review of the home's Falls Prevention Program, revised December 2017, indicated incontinence as a risk factor for falls and continence management is a part of the post fall protocols as per the program. Falls preventative measures included bowel and bladder programs aimed at restoring bowel and bladder functions or containment and establishing individualized toileting schedules for residents.

Interview with the DOC indicated that the written plan of care is to be reviewed and revised when the current strategies were not effective.

On an identified day, the DOC sent documents as requested by the inspector, including a copy of the written care plan to the inspector. The documents indicated that staff were to toilet the resident upon request, and a note was made by the DOC indicating that the

resident was independent in toileting, and could be incontinent and will ask for assistance, which is contrary to the statements provided by staff during interviews, that the resident was incontinent some days and would forget to ask for help or to use the call bell.

Based on the documentation, staff interviews and the resident having repeated falls while trying to use a washroom independently, and no specific intervention in relation to the cause of the falls, the inspector issued this non-compliance. [s. 6. (11) (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 to ensure there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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, r. 48 (1) (1). Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the home's Falls Prevention Program, revised December 2017, indicated that the resident will be assessed after each fall. The assessment will include but not limited to the evidence of seizure activity, injury, damage for hip joint for extreme pain, shortening, inability to weight bear, and to assess for limited Range of Motion (ROM) on joints avoiding any undue stress on joints. Assist the resident to get up if it has been determined that the resident can move. Observe for facial expression, guarding or complaints of pain. If the resident is unable to weight bear, do not move the resident, call ambulance and prepare a transfer to the hospital for assessment.

A review of the CIS report, indicated that on an identified day, resident #001 was found on the floor in their room. Upon asking, the resident reported that the resident was standing and did not know what happened. The resident was lifted from the floor by staff, and assessment was completed. The resident complained of severe pain and was found with a change in the health condition. The resident was admitted to the hospital with an injury. The resident was discharged from the hospital to a palliative care unit on an identified day.

A review of the Fall Incident Risk Management report, indicated that the staff called the registered staff and found the resident on the floor in the room. The resident complained about severe pain on an identified body area. The resident was transferred to bed by three staff and was assessed. The resident complained about severe pain by holding an identified body part. Two nurse managers came, and the PT assessed the resident. The resident was found with a change in the health condition. The resident reported, upon asking, that they were standing and did not know what happened. The paramedics were called and the resident was transferred to the hospital.

Interview with the Program Therapist #100 indicated that they went to invite the resident for the program and found the resident on the floor, and immediately informed RN #102, and left the room.

Interview with the PSW #101 indicated that, as per the home's policy the resident should have been left on the floor comfortably, and the registered staff should have assess the resident and transferred to the hospital based on the severe pain and a change in the

health condition.

Interview with RN #102 indicated that the program staff called them and reported that the resident was on the floor. By the time, RN #102 reached to the resident's room, the resident was on the floor and reported a severe pain in an identified body area. Three people including RN #102 transferred the resident to the bed without using a lift and then upon assessment the resident was found with a change in the health condition as well as having severe pain in an identified body area. The resident was transferred to the hospital for further assessment. RN #102 indicated that the resident was transferred to the bed so they can complete a proper assessment.

Interview with PSW #101, #103, #104, RPN #106, Nurse Manager #105, Physiotherapist (PT), indicated that the resident should not have transferred to the bed or on to the wheelchair before the registered staff completes the assessment. The resident should have been assessed prior to transfer on the bed as per the home's policy.

Interview with RN #110, Nurse Manager #108, #109, the PT indicated that the resident should have been assessed after the fall before being transferred to the bed.

Interview with the DOC indicated that the resident was assessed by the RN, and RN is a trained professional, they are not the people from the street, they know what they need to do. There was some kind of assessment completed including environment check, and pain assessment before they transferred to the bed, however the DOC was not able to explain the reason for the ROM not being completed by the RN.

Based on the documentation, policy review, staff confirmations and significant change in the resident's health status, the inspector issued this non-compliance. [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 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, 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 :

1. The licensee has failed to 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.

A review of CIS report, indicated that resident #002 was found on the floor, in their room on an identified day. The fall was not witnessed. A specific device had been removed by the resident. A post-fall assessment was conducted by the nurse on the unit. Assessment revealed severe pain in an identified body area. Resident was unable to perform ROM. The resident was transferred to the hospital as per physician's recommendation. On an identified day, the hospital informed the facility that the resident has been admitted with an injury.

A review of the resident's written plan of care indicated that the resident was at risk for falls due to deceased balance, unsteady gait, and use of a specific medication.

A review of resident's progress note indicated that on an identified day, PSW called the nurse and informed that the resident was on the floor. The resident was alert, and complained about pain in an identified body area. The resident was unable to perform ROM due to pain, and the resident was transferred to the hospital.

A review of the CIS and the resident's progress notes indicated that the resident had a history of falls on three identified days.

A review of the resident's clinical record indicated that there was no Risk Incident Management (RIM) completed for the above mentioned three incidents of falls. RIM was completed for the above mentioned incident indicated in the CIS report.

A review of the home's Falls Prevention Program, revised December 2017, indicated that all residents will be assessed post falls to determine the extent and type of injury and to assess contributing factors that may have caused the fall using a tool specifically designed for this purpose. The resident will be assessed after each fall using the RIM assessment and Fall Incident progress note template in the electronic documentation system.

Interview with the RPN #102, RN #110, Nurse Manager #119, and the DOC confirmed that the RIM should have been completed at the time of the fall and progress notes should be documented using a template as per the home's policy. [s. 49. (2)]

Issued on this 29th day of August, 2018

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

Original report signed by the inspector.