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 12, 2019	2019_767643_0018	003987-19, 005176-19, 005710-19	Critical Incident System

Licensee/Titulaire de permis

Don Mills Foundation for Seniors
1 Overland Drive TORONTO ON M3C 2C3

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

Thompson House
1 Overland Drive NORTH YORK ON M3C 2C3

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

ADAM DICKEY (643)

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 3-7, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #003987-19, CIS #C573-000001-19 - related to injury with unknown cause; and
Log #005176-19, CIS #C573-000003-19 - related to falls prevention and management.

The following Compliance Order (CO) follow-up intake was inspected during this inspection:
Log #005710-19 - related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Behavioural Support Nurse, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, transfer audit records, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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
O.Reg 79/10 s. 36.	CO #001	2019_644507_0005	643

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 written plan of care for resident #002 set out the planned care for the resident to manage identified responsive behaviours.

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #002 who sustained an injury and was taken to hospital and a significant change in condition occurred. Review of the CIS report showed on an identified date, evidence of injury was noted by staff. Two days later additional evidence of injury was observed and resident #002 was sent to hospital for assessment and diagnosed with a specified injury.

Review of resident #002's Minimum Data Set (MDS) assessment data showed they had exhibited two identified behavioural symptoms on one to three days in the observation periods for the two quarterly reviews conducted prior to the resident's above injury. Review of MDS assessment completed following their return from hospital showed the above mentioned behaviours were exhibited daily during the observation period.

Review of resident #002's progress notes showed six documented instances in which the resident exhibited the above identified responsive behaviours during the six months prior to sustaining the above injury.

In interviews, PSWs #108 and #114 indicated that resident #002 had been exhibiting the above identified responsive behaviours for a long period prior to sustaining the above injury. Both PSWs indicated that when presenting with these behaviours, staff would employ a specified behavioural intervention and always needed two staff to provide care.

In interviews, RNs #110 and #116 indicated that resident #002 had been exhibiting the above responsive behaviours for up to a year, and staff were instructed to employ specified behavioural interventions when working with them. Both RNs indicated that these interventions should have been included in the written plan of care for resident #002 to manage the behaviours. RN #116 indicated that resident #002's care plan was not updated to include interventions to manage their behaviours until after the injury occurred.

In an interview, Behavioural Support RPN #117 indicated that residents exhibiting responsive behaviours would have care plan interventions included in their plan of care when new behaviours occurred. RPN #117 indicated that when staff were using interventions to manage these behaviours they should be discussed with the interdisciplinary team and care planned, and that these interventions were not included in resident #002's plan of care when the behaviours began to occur. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the written plan of care for resident #005 set out clear directions to staff and others who provided direct care to the resident related to transfer assistance.

Review of resident #005's plan of care showed under a focus for risk for falls that the resident required extensive assistance from one to two staff members for transferring. Further review of the plan of care showed under a focus of transfer assistance that resident #005 required extensive assistance of two staff members for transferring. Observation in resident #005's room showed a transfer logo indicating two person transfer.

In an interview, PSW #100 indicated that the resident was able to transfer with the assistance of one staff member when initially approached by the inspector. In a subsequent interview, PSW #100 indicated that resident #005's plan of care showed two person assistance for all transfers.

In an interview, RN #101 indicated that they were scheduled to review and revise

resident #005's care plan as their quarterly review had come up that week. RN #101 reviewed the written plan of care and indicated that the directions to staff showed one to two person assistance in one section of the plan and two person assistance in another section. RN #101 indicated that this direction was not clear related to the number of staff required to assist resident #005 with transferring.

In an interview, PT #105 indicated that they had reviewed resident #005's transfer status and assessed them to be safe to transfer with one person assistance when they were alert and not confused. PT #105 indicated that resident #005's cognitive status varied and at times would require two staff members to assist with transferring. PT #105 indicated that the plan of care for transferring assistance would be updated by the nursing staff and should match throughout to provide clear direction to staff assisting resident #005 with transferring. [s. 6. (1) (c)]

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

Observation by the inspector on an identified date, showed PSW #102 transporting resident #004 on an identified resident home area using a specified mobility device. Subsequent observation on the same identified date showed PSW #102 transporting resident #004 using the above mobility device for transport to an identified meal service.

Review of resident #004's plan of care showed that staff were to ensure the resident avoided use of an identified feature of the above identified mobility device. Under the focus for mobility the staff were instructed to assist resident with transport using a second specified mobility device under specified circumstances.

In an interview, PSW #102 indicated that resident #004 was experiencing pain and was assisting them with transport using the first above identified mobility device. PSW #102 indicated that they were aware that the second identified mobility device was available in the home if a resident needed the device temporarily. PSW #102 indicated that they were not aware that the first above identified mobility device was not to be used for transporting resident #004.

In an interview, RN #101 indicated that staff had been instructed to use the second identified mobility device for resident #004 in an identified circumstance. RN #101 indicated they were aware that resident #004 had pain and was administering analgesic medication to treat the pain. RN #101 indicated that the second above mentioned

mobility device was available if residents needed to use one on a temporary basis on the above identified resident home area.

In an interview, PT #105 indicated that using the first above identified mobility device in the identified manner was not safe for residents. PT #105 indicated that resident #004 had the second identified mobility device available that could be used if needed. PT #105 indicated that based on the resident's mobility care plan staff did not provide the care set out in the plan as they were instructed to use the second identified mobility device for transport if the resident was unwell. [s. 6. (7)]

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 with ensuring that the written plan of care for each resident sets out the planned care for the resident; and
with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On March 4, 2019, the following compliance order (CO #001) from inspection number

2019_644507_0005; amended on April 29, 2019, inspection number 2018_644507_0005 (A1) was made under O. Reg. 79/10, s. 36. was issued:

The Licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the Licensee must:
1) Ensure that for resident #001 and all residents who require mechanical lift for transferring, that the size of the sling use for the resident is based on the manufacturer's guideline and is included in the resident's written plan of care.
2) Ensure that staff use safe transferring techniques to assist resident #005 and all residents who require assistance with transferring as specified in the resident's written plan of care.
3) Develop an auditing system in the home to ensure that all residents who require mechanical lift for transferring, that the size of the sling used for the resident is included in the resident's written plan of care.
4) Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to the resident's written plan of care.
5) Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the action required as the result of the audit.

The compliance date was May 31, 2019.

The licensee completed step(s) 2, 3, 4 and 5 in CO #001.

The licensee failed to complete step 1.

As part of the follow-up inspection for CO #001 resident #005's written plan of care was reviewed. Review of the resident's care plan showed that the resident required the use of an identified mechanical lift under specified conditions. The written plan of care did not include documentation of a sling size for resident #005.

In an interview, RN #101 indicated that staff would use the identified mechanical lift under specified conditions. RN #101 indicated that they were unsure what sling size resident #005 would use when being assisted with the mechanical lift. RN #101 indicated that the sling size had not been care planned yet for residents who only used the mechanical lift occasionally.

In an interview, RPN #104 indicated that they had been working on measuring all residents who required the use of mechanical lifts in order to properly fit them for transfer slings and documenting in the plan of care. RPN #104 indicated that resident #005 did not have a sling size documented as they had not completed resident's sling sizes if they only occasionally required the use of mechanical lifts. [s. 101. (3)]

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 with every order made under this Act, to be implemented voluntarily.

Issued on this 13th day of June, 2019

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

Original report signed by the inspector.