**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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**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 |
|---|---|---|---|
| Oct 7, 2019 | 2019_769646_0014 | 013740-19, 016458-19 | 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**

IVY LAM (646)

## 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): September 26, 27, and 30; and October 1 and 2, 2019.**

**The following Critical Incident System (CIS) intakes were inspected during this inspection:**
**Log # 013740-19, CIS #C573-000009-19 - related to injury for which the resident was taken to hospital and which resulted in a significant change; and**
**Log #016458-19, CIS #C573-000012-19 - related to falls prevention and management.**

**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), Recreationist, Laundry Staff, Personal Support Workers (PSW) and residents.**

**During the course of the inspection, the inspector conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, the home's investigation notes, transfer audit 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.**
**2 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

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

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to injury to resident for which resident #002 sustained an injury and was taken to hospital and a significant change in condition occurred. Review of the incident report and the resident's progress notes showed that resident #002 had a fall on an identified date, and was assessed by the registered staff with no injuries identified. The resident's range of motion was assessed by the physiotherapist (PT) the next day, with no pain identified. Two days after the initial fall, resident #002 was found to be leaning to their side when seated, was identified with pain upon assessment, and was transferred to the hospital on the same day. The resident was diagnosed with a specified injury at the hospital.

Review of the resident's care plan showed that resident #002 was at risk for fall related to identified risk factors, including ambulating without their identified assistive device. Resident #002's falls prevention interventions at the time included: monitoring closely by all staff at an identified home area, or to bring the resident to another identified area if staff were not able to provide the identified care.

Review of the home's risk management assessment showed that resident #002 was found to have fallen in the first identified home area, and that prior to the fall, the resident had ambulated without their identified assistive device.

Interview with laundry staff #104 stated that they saw resident #002 ambulating without their assistive device towards an identified home area, but by the time they had reached the resident, the resident had fallen. The laundry staff stated that they did not see any staff in the area prior to the resident's fall, and had called out for staff assistance, and two Personal Support Workers (PSWs) responded and arrived on scene.

The inspector interviewed the registered staff and the three PSWs assigned on shift on the second floor on the day of the incident. Interview with PSW #112 stated that they were assisting another resident in their room at the time of the incident and heard laundry staff #104 call for assistance. The PSW stated that they only saw the laundry staff with the resident at the time and did not see any other PSWs, the nurse, or the receptionist at the time. They further stated that the nurse was not on the floor and had called the nurse on another floor to assess the resident. The PSW stated that resident #002 had their identified assistive device beside them in the identified home area when they last observed the resident.

Interview with PSW #103 who was assigned to resident #002 on the date of the incident stated that they did not regularly work with the resident and had not read resident #002’s care plan prior to providing care that day, but had asked the other PSWs about what care resident #002 needed. When resident #002 finished their meal, PSW #103 had tried to assist the resident out of the identified home area, but the resident refused. PSW #103 asked PSW #105 what to do for the resident as the resident remained seated in the identified home area, and PSW #105 had responded to leave the resident there as there will be another activity happening soon in the area. PSW #103 then went to assist another resident out of the identified home area. PSW #103 further stated that they had left the identified home area for an identified period of time prior to hearing the staff call their name for assistance, and that no one was monitoring the resident at the time of the resident’s fall.

Interview with PSW #105 stated that they were the last staff member in the identified home area, and had left to take another resident out of the identified home area. The PSW stated they had left for an identified period of time before hearing sounds in the identified home area and arrived to see that resident #002 had fallen. The PSW called for PSW #103 to come, and went to call for the nurse from another floor as the nurse on the floor was not there at the time. The PSW further stated that there were no PSWs or registered staff monitoring the resident at the time as they were all busy.

Interview with Registered Nurse (RN) #115 stated that they had gone on their break at the time and was not in the area.

Interview with the Assistant Director of Nursing (ADON) stated that it was the home’s expectation for staff to provide care to the resident as specified in the resident’s care plan. The ADON stated that resident #002 was at risk for falls and the fall prevention intervention included monitoring the resident closely when the resident was in the identified home area, or to bring the resident to another identified area if staff were not available. The ADON further stated that it was the home’s expectation for a staff member to be in the identified area to observe resident #002 and ensure that the resident was safe, and this was not done. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS Report was submitted to the MLTC related to an incident where resident #001 sustained an identified injury while being ambulated in their mobility device by PSW #101. During the process, the PSW did not see that an identified part of resident #001’s body was caught in the identified mobility device until the resident called out. The resident was assessed by RPN #109 and RN #106 and was sent to hospital on the same day for further assessment. Resident #001 returned to the home the next day with a specified injury.

Review of resident #001’s care plan in place at the time of the incident showed that the resident required an identified mechanical lift with a specified number of staff members for assistance.

Review of the home’s investigation notes showed that PSW #101 had transferred the resident from the identified mobility device to the resident’s bed on their own without using the identified mechanical lift specified on resident #001’s care plan prior to requesting RPN #109 to assess the resident.

Interview with PSW #101 showed that the PSW had performed an identified transfer for resident #001 on their own with from bed to the resident’s identified mobility device,

without using the specified mechanical lift, on the morning of the incident; then again performed the identified transfer without the specified mechanical lift on their own for resident #001 from the identified mobility device to bed. PSW #101 stated that they were aware that resident #001’s care plan specified that the resident needed an identified mechanical lift to transfer the resident from bed to their identified mobility device. The PSW further stated that they had looked for other staff members for assistance with transfer but did not find anyone that day, and had transferred the resident using another method of transfer on their own instead.

Interview with RPN #109 stated that when they had arrived to assess resident #001 on the day of the incident, the resident was already in bed, and the RPN was not sure how the PSW had transferred the resident that day. RPN #109 further stated that the PSWs should call the registered staff to assist with transfers if needed.

Interview with RN #106 stated that they did not know how resident #001 was transferred from their mobility device to bed on the day of the incident, but that resident #001 needed an identified mechanical lift for transfers as they were unable to be transferred using other methods of transfer.

Interview with the ADON and Director of Nursing (DON) stated that staff are expected to follow the resident’s care plan for transfer, and that PSW #101 did not use safe transferring and positioning devices or techniques when assisting resident #001 on the day of the incident. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

**Issued on this 8th day of October, 2019**

| **Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs** |
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**Original report signed by the inspector.**