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

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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
Jan 21, 2020	2020_530726_0001	019437-19, 022463-19	Critical Incident System

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

REBECCA LEUNG (726)

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): January 8, 9, 13 and 14, 2020.

The following Critical Incident System intakes were inspected during this inspection:
Log #019437-19 and Log #022463-19 related to falls prevention.

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

During the course of the inspection, the inspector reviewed the home's policy, call bell log reports and residents' clinical information, and observed staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's right not to be neglected by the licensee or staff was fully respected and promoted.

Critical incident system (CIS) report was submitted to the Ministry of Long-Term Care on an identified date, related to a fall incident involving resident #001. Review of the CIS report and an identified report indicated that on an identified date and time, resident #001 was found on the floor at an identified location with their mobility device beside them. Resident #001 reported to the staff that they had tried to transfer themselves unassisted, and they missed the mobility device as it was not locked. The resident complained of pain in an identified body part after the fall and was transferred to the hospital for assessment.

Review of a specified home's policy indicated that all team members were expected to respond to the call bell immediately following it being initiated.

Review of the identified notes indicated that resident #001 was identified with a specified diagnosis and received a specified surgical treatment. The resident returned to the home on an identified date and was started on a specified therapy.

In an interview, the physiotherapist (PT #107) stated that resident #001 continued to receive the specified therapy and the resident had returned to their baseline functions, and continued to use the mobility device to assist with mobility. PT #107 stated that resident #001 required specified assistance for transfers, remained at a specified risk level for falls, and the resident had attempted to go to washroom unassisted after returning from the hospital. PT #107 stated that the fall interventions put in place included the application of various specified equipment as indicated in the resident's care plan.

Review of an identified note for an identified date, indicated that resident #001 was admitted with a specified diagnosis with an identified functional impairment. Review of an identified assessment completed on an identified date, indicated that the resident was identified with a specified problem and another identified functional impairment.

In an interview, resident #001 stated that on the date of the incident, they rang the call bell before going to the washroom by themselves. They waited for a long time, but nobody came. Resident #001 stated that the staff had advised them to call for help and avoid doing self-transfers without assistance. However, when they rang the call bell to get help for going to the washroom or going to bed, it usually took a long time for the staff to come. Resident #001 said that it took a specified period of time for the staff to respond

to their call bells sometimes, and up to another specified period of time occasionally. Resident #001 said that they had gone to the washroom without ringing the call bell for help because they needed to go right away, and the staff took too long to come.

Review of an identified report of the identified floor for the date of incident, indicated no call bell was initiated from resident #001’s bedside or washroom within a specified period of time before resident #001 was found on the floor in their washroom.

Review of an identified report of the identified floor for a specified time frame indicated that significant delays in the staff response time were noted on a specified number of occasions.

In the interviews, PSW #100, RPN #109, RPN #113 and PT #107 stated that they were expected to respond to the call bells initiated by residents as soon as possible, usually within a specified range of time to ensure that resident #001 was safe. They stated that the delay in the staff’s response to resident #001’s call bells could put the resident at increased risk for falls as the resident might do the self-transfer unassisted. PSW #100, RPN #109, and RPN #113 said that if they were assisting another resident and unable to answer the call bell, they could use their portable phone to call another staff to help answering the call bell for the resident to avoid the delay.

In the interviews, RPN #109 and RPN #113 stated that the significant delays in staff response time were unacceptable and acknowledged that the staff had failed to ensure that resident #001’s right not to be neglected was respected.

In an interview, the director of care (DOC) stated that the staff were instructed to respond to call bells initiated by the residents in a timely manner. In case the staff were busy with assisting a resident, they could use their portable phone to communicate with another team member. The DOC reviewed the identified report as mentioned above and confirmed that the significant delays in the staff response time to the call bells initiated by resident #001 were unacceptable. The DOC acknowledged that the home had failed to ensure that resident #001’s right not to be neglected by the staff was respected and promoted. [s. 3. (1) 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 to ensure that the right of residents not to be neglected by the licensee or staff is fully respected and promoted, to be implemented voluntarily.

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.