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 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
May 24, 2019	2019_740621_0014	005998-17, 008922-17, 025205-17, 003523-18, 006116-18, 006592-18, 018488-18, 019840-18, 029306-18	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

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): May 6 - 10, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

Four intakes related to resident falls that resulted in a significant change in health condition;

One intake related to alleged resident to resident abuse and falls management;

Two intakes related to alleged staff to resident abuse; and

Two intakes related to the home's mandatory and critical incident reporting processes.

Additionally, a Complaint inspection #2019_740621_0015 and Follow Up inspection #2019_740621_0013 were completed concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Personal Support Workers (PSWs), a Resident Assessment Instrument (RAI) Coordinator and a Dietary Aide.

The Inspectors also conducted a daily tour of resident care areas, observed staff to resident, and resident to resident interactions, and reviewed relevant health care records, home's investigation records, Critical Incident System (CIS) reports, and applicable licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted to the Director on a day in March 2017, which alleged staff to resident physical and verbal abuse of resident #006 by Personal Support Worker (PSW) #106, on another day in March 2017.

Inspector #693 reviewed the progress notes composed by RN #104 for resident #006, from a specific date in March 2017, which identified that the RN had notified the previous DOC of the allegations of abuse, made by resident #006.

During an interview with RN #106, they stated that if a resident made an allegation of abuse they were to report it right away to their manager. RN #106 explained that any allegation of abuse or neglect, needed to be reported to the Director immediately. RN #106 stated that if an allegation of abuse was reported one day later, this would not be appropriate as it would not be considered immediate reporting.

Inspector #693 reviewed the home's policy, titled, "Managing and Reporting Complaints, AD-0515-00", published on January 1, 2016. The policy indicated that if a complainant alleged suspected or witnessed abuse of a resident, by anyone or neglect of a resident

by staff, the home was required to have immediately informed the Director. A review of the home's policy, titled, "Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements, HC-01150-00", published January 7, 2014, indicated that a mandatory critical incident report was required to be submitted to the Ministry of Health and Long-Term Care (MOHLTC) immediately for allegations of abuse of a resident by anyone.

During an interview with the Administrator, they stated to Inspector #693 that any allegation of abuse or neglect was required to be reported immediately to the Director. The Administrator stated that if an allegation of abuse occurred after hours, when management was not in the home, the RN in Charge was required to notify management and to call the MOHLTC after-hours pager to report the incident, immediately. They stated that the allegation of physical and verbal abuse made by resident #006 on a specified date in March 2017, should have been reported immediately and it was not. [s. 24. (1)]

2. A Critical Incident Systems (CIS) report submitted to the Director on a specific date in July 2018, which outlined physical abuse by resident #011 to resident #012 resulting in a fall with injury. The incident was reported to have occurred three days earlier, on another specific date in July 2018, with management of the home aware that the incident was suspected as abuse on another specified date in July 2018.

In an interview with Inspector #744, Dietary Aide #118 identified that they had witnessed the incident of physical abuse by resident #011 towards resident #012 on a certain date in July 2018, but identified that they did not report the incident until the next day to their manager.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect, RC-0305-11", published August 1, 2016, identified that the Director of Care (DOC) must notify the Ministry of Health and Long-Term Care (MOHLTC) immediately that an alleged, suspected or witnessed incident of abuse or neglect had become known and an investigation was underway.

In an interview with Inspector #744, the DOC stated immediate reporting should have been done the same day the home was aware of the abuse. The Inspector reviewed the CIS report with the DOC, and upon review, the DOC identified that the witnessed physical abuse should have been immediately reported to the MOHLTC after-hours report line when management became aware. [s. 24. (1)]

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 Personal Support Worker (PSW) #101 used safe transferring and positioning devices or techniques when assisting resident #005 on a specific date in October 2017.

A Critical Incident System (CIS) report was submitted to the Director on a specified date in October 2017, which alleged neglect of resident #005. The CIS report indicated that staff consulted with the Nurse Practitioner (NP) on a specific date in October 2017, regarding their suspicion that the resident had a particular medical condition on a particular location of their body. The CIS report further identified that on another date in October 2017, Physician #103 assessed resident #005 and identified that the area of concern was in fact an injury that was related to staff's handling of resident #005 during care.

Inspector #693 reviewed the home's investigation notes, which identified that the home determined that, PSW #101 used a mechanical lift device by themselves to transfer resident #005. The investigation notes included an interview with PSW #101; in which, PSW #101 stated that they were familiar with resident #005's care plan, and it indicated that two staff were required for transferring the resident using a particular mechanical device, but that they had transferred resident #005 with the device on their own. The investigation notes stated that the care plan that was in place at the time of the incident, indicated that resident #005 required the assistance of two staff members when the mechanical lift device was used with them during care.

During an interview with PSW #102, they stated that all PSWs received training on safe transferring and positioning techniques during orientation, as well as annually. PSW #102 stated that they knew the level of transfer assistance that a resident required, from reading the resident's care plan. The PSW stated that if a resident utilized a mechanical lift device to transfer, two staff members were required to complete the transfer in a safe

way.

The Resident Assessment Instrument (RAI) Coordinator #120 provided Inspector #693 a copy of resident #005's care plan that was current. The care plan indicated that resident #005 had a specific level of dependence for transferring, including the use of a mechanical lift device, which required two staff members.

The Administrator provided Inspector #693 a copy of the home's policy, titled "Mechanical Lifting Device, NU-0606-00", last revised January 2019. The Administrator stated that this policy was current during the incident in October 2017. The policy indicated that the staff were to check the resident's care plan to determine the correct mechanical lifting device and type of sling to be used, as well as any resident specific instruction. The policy also indicated as a safety alert that all mechanical lifts required two caregivers to operate.

During an interview with the Administrator, they stated that PSW #101 did not follow the home's policy or resident #005's care plan, when they transferred resident #005 utilizing a mechanical lift, without the assistance of another staff member during a specific shift in October 2017. The Administrator stated that PSW #101 did not use safe transferring and positioning devices or techniques when assisting resident #005. [s. 36.]

2. The licensee has failed to ensure that RN #104 used safe positioning techniques when assisting resident #006.

A Critical Incident System (CIS) report was submitted to the Director, which alleged staff to resident physical and verbal abuse of resident #006. The CIS report indicated that resident #006 had notified RN #104, of an allegation of physical and verbal abuse by PSW #106.

Inspector #693 reviewed the home's investigation notes and identified that the home was unable to verify the alleged abuse, but that the home identified that RN #104 did not follow resident #006's care plan, when they repositioned the resident during care on the specified date in March 2017.

Inspector #693 reviewed the progress notes for resident #006, which indicated that the RN had repositioned resident #006 during a particular care activity, on their own, and without the assistance of another staff member.

Resident #006's care plan, was reviewed by Inspector #693. The care plan, indicated that resident #006 required two-person assistance with repositioning during a particular care activity.

During an interview with RN #105, they stated that the level of assistance a resident needed, with repositioning, would be indicated on their care plan. RN #105 stated that if a resident's care plan indicated that they required the assistance of two staff to reposition, then all repositioning should have been done with two staff members, and if one staff member repositioned the resident on their own, this would mean they had not utilized a safe positioning technique.

Inspector #693 reviewed the home's policy, titled, "Repositioning a Resident, RC-0522-14", last updated January 2019. The policy included an attachment titled, "Diagrams and Instructions", the instructions outlined that before staff repositioned a resident, they were first required to check the resident's care plan to confirm the repositioning method that was needed for the resident.

During an interview with the Administrator, they stated that staff were to preform safe positioning of residents by following the instructions on each resident's care plan. The Administrator stated that, RN #104 did not use a safe positioning method when they assisted resident #006, with a specific care activity. The Administrator stated that two staff members should have repositioned resident #006, as per the care plan, in order to have utilized a safe positioning technique. [s. 36.]

Issued on this 24th day of May, 2019

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

Original report signed by the inspector.