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
Jun 25, 2019	2019_790730_0016	000588-18, 000019-19, 007029-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Fudger House
439 Sherbourne Street TORONTO ON M4X 1K6

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

CHRISTINA LEGOUFFE (730), KRISTEN MURRAY (731)

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 17, 18, 19, 20, and 21, 2019

The following Critical Incident System intakes were completed within this inspection:

Related to falls prevention:
Critical Incident Log #007029-19/ CI M524-000009-19

Related to missing residents:
Critical Incident Log #000588-18/ CI M524-000002-18
Critical Incident Log #000019-19/ CI M524-000001-19

During the course of the inspection, the inspector(s) spoke with an Administrator, an Assistant Administrator, Nurse Mangers (NMs), a Registered Social Service Worker (RSSW), Registered Nurses (RNs), and Personal Support Workers (PSWs).

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with LTCHA, 2007, 87. (1), the licensee was required to have written emergency plans in place for the home that complied with the regulations. Furthermore, in accordance with O. Reg. 79/10, s. 230 (4) 1. vii, the licensee was required to have written emergency plans for dealing with situations which involved missing residents.

Specifically, staff did not comply with the home's "Missing Resident- Code Yellow" policy (EM-0501-00, Published March 2018), which was part of their Emergency Management plan.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), on a specified date, related to an incident where resident #003 was missing from the home for more than three hours.

The home's policy titled "Missing Resident- Code Yellow" outlined three stages of guidelines under the procedure. During stage one the policy stated in part that "Upon determining that a resident cannot be accounted for on the resident unit for any reason, notify the Nurse Manager/designate and indicate the approximate time and place the resident was last seen." Point three in stage one stated that "If the resident is not located within 15 minutes from the time they were identified as missing, proceed to Stage Two." Stage two of the procedure stated in part that "The Unit Captains shall provide the completed Code Yellow: Missing Resident Form and building checklists to the Logistics Captain" and that a coordinated search of the entire home and completion of the

checklists was required. This section further indicated that if the resident was not located within 30 minutes from the time stage two was initiated that they would proceed to stage three. Stage three of the procedure stated that "If the risk is assessed as high, a more exhaustive search must take place and the Administrator Administrator/designate shall notify, or if after hours authorize the Incident Manager to notify Toronto Police Services…"

The CIS report stated that on a specified date, resident #003 was last seen on a unit in the home by another resident.

A review of the progress notes in resident #003's paper chart showed that between specified times staff notified the on-call manager and a building search was initiated, which included searching outside the home on a nearby street and a store that the resident frequented. Later, a progress note stated that the resident's family member had been notified and they stated that they wanted the police to be called if the resident did not return to the home. This note stated that a building search was conducted.

A progress note the following morning stated that another search was done for resident #003 in the building and outside in the surrounding areas, but the resident was not located. A progress note at about five hours after the search was initiated, stated that the on-call manager and administrator had been notified that the resident did not return for the night. The administrator advised staff to call the MOHLTC and police.

A progress note stated that the police and MOHLTC after- hours were called. A later progress note stated that the resident's family member called the home and stated that resident #003 had called them from the community and that another family member went to pick up the resident to return them to the home.

During an interview with Registered Nurse #102 they stated that the procedure in the home related to missing persons was a Code Yellow. They stated that if the resident was not located after 45 minutes that they would go to stage three of the procedure. They stated that during stage three the incident manager and police would file a missing persons report.

During an interview with Nursing Manager #105, they stated that a Code Yellow was called in the home when resident #003 went missing. Nursing Manager #105 stated that the home did not follow the Code Yellow Procedure related to timelines for notifying the police when resident #003 went missing from the home.

A review of the investigative notes did not contain a "Code Yellow: Missing Resident Form" related to this incident.

Administrator #100 stated that it would be their expectation that a Code Yellow form would have been completed, however, they were unable to locate one completed related to this incident.

The licensee has failed to ensure that when resident #003 went missing that the home complied with their emergency plan related to missing residents. [s. 8. (1)]

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 "Missing Resident- Code Yellow" Policy is complied with, to be implemented voluntarily.

WN #2: 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 had fallen, the resident was assessed and a post-fall assessment was conducted, using a clinically appropriate assessment instrument that was specifically designed for falls.

On a specified date, the home submitted a Critical Incident System (CIS) report to the

Ministry of Health and Long Term Care (MOHLTC) regarding a fall of resident#001 that resulted in a fracture and required surgical intervention.

In a clinical record review for resident #001, the progress notes identified that resident #001 was found on the floor of their room. The next day, resident #001 was sent to hospital, was diagnosed with a fracture, and required surgical repair. The progress notes stated that on a specified date resident #001 returned from hospital, and the following day resident #001 was found on their right side, on the floor mattress, beside the bed.

In a clinical record review for resident #001, no Post Fall Assessment Huddle documentation was identified in the resident's chart for the fall on the day after they returned from hospital.

In an interview with Registered Nurse (RN) #108, they stated that the Post Fall Assessment Huddle was a paper document that was to be completed for every fall by a registered staff member and that the strategies put in place after the fall of a resident were discussed with the team. When asked if a Post Fall Assessment Huddle was completed for resident #001's fall, after they returned from hospital, RN #108 stated a head to toe assessment was completed and head injury routine was initiated but no Post Fall Assessment Huddle was completed after the fall. When asked if the expectation was that a Post Fall Assessment Huddle should have been completed after the fall for resident #001, RN #108 stated yes, there should have been one completed in order to review strategies and if they were still working for the resident.

In an interview with Nurse Manager (NM) #109, they stated that the Post Fall Assessment Huddle document was the home's clinically appropriate Post Fall Assessment tool and was to be completed by a registered staff member, immediately after every fall. When asked if a Post Fall Assessment was completed for resident #001 after their fall, NM #109 stated that it was not. When asked if the expectation in the home would be that a Post Fall Assessment should have been completed, NM #109 stated yes, it should have been completed.

The home's policy #RC-0518-21, titled "Falls Prevention and Management", stated in part "A Post Fall Assessment Huddle shall be completed after each fall prior to the end of the shift".

The licensee failed to ensure a post-falls assessment had been conducted when resident #001 fell. [s. 49. (2)]

Issued on this 25th day of June, 2019

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

Original report signed by the inspector.