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 31, 2020	2020_804600_0002	014429-19, 018229-19, 018716-19, 020746-19, 000247-20	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

GORDANA KRSTEVSKA (600)

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 14, 15, 16, 17, 20, 21, 2020.

During this inspection the following intakes had been inspected:
#014429-19, #018229-19, 018716-19, related to falls,
#020746-19,related to missing resident;
#000247-20, related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager - Clinical (NM-C), Nurse Manager - Operative (NM-O), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian - Manager Clinical Nutrition Services (RD), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, resident and staff interactions, the provision of residents' care, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status.

A review of resident #003's health record indicated they were high risk for fall.

A review of the resident’s plan of care before and after the incident indicated that there was no plan of care for resident #003 to indicate that the home had placed preventative measures to prevent fall incidents as the resident was identified to be at risk.

An interview with Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #105 indicated that the resident had a physical condition that, when they sit the resident in an assistive device, they must keep the device in a specified position all the time. Due to their condition, the resident also changed their position when seated, so they repositioned the resident very often. Both staff stated that the resident was at risk for fall, however they were not able to explain if there was developed a plan of care for fall prevention.

In an interview, the Nurse Manager - Clinical (NM-C) indicated that because the resident did not have any incident in the previous quarterly review, they discontinued the plan of care for fall prevention, until the resident has a fall. In an interview with Nurse Manager - Operation (NM-O), they indicated that on the risk assessment, resident #003 was identified to have a potential for risk, so that is why they did not create a plan of care for the resident.

In an interview, the Director of Nursing (DON) acknowledged that according to the home’s clinically appropriate assessment tool and the interview with the staff, the resident was identified to be at high risk for fall however, there was no plan of care for resident #003 based on an interdisciplinary assessment with respect to the resident's health conditions and identified risk of falls. [s. 26. (3) 10.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report was submitted to the MLTC on an identified date regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of resident #003's MDS assessment indicated that the resident was on an identified treatment on a regular basis and did not have pain within the observation period of few days prior the assessment.

A review of the treatment management record indicated that the resident had been assessed for pain on an identified date, and had no pain. The record also indicated that the resident's pain had been well managed with the treatment taken on regular basis.

A review of the resident's progress notes from a specified date, indicated that RPN #105 documented at the end of the shift that PSW #104 reported resident #003 complained of pain to an identified body part. Upon assessment the resident complained of the pain when they moved. Scheduled treatment was given with fair effect. Skin alteration was noted on the identified body part. Note left for in house doctor to assess. Continued to monitor.

In an interview, PSW #104 indicated that on the identified date, while providing care, resident #003 complained to PSW that they were having an identified pain pointing towards body parts, but not able to explain exactly where. Further the PSW indicated that

the resident usually complained of generalized pain every time when they provide care in the morning if the resident did not have their treatment yet. The PSW dressed the resident and wheeled them outside in the hallway and told RPN #105 that resident #003 had pain, pointing to the body part. The PSW stated that the RPN administered the treatment to resident #003 and PSW wheeled the resident to the dining room. PSW #104 also stated that when they wheeled the resident from dining room back to their room resident #003 started complaining of the pain again. Then the PSW noted that the resident's identified body part had a skin alteration. The PSW called an RPN who came in the room, looked at the resident and they applied another treatment to the resident's body part. The PSW indicated that RPN #105 saw the PSW applying a different treatment on the resident's body part but did not ask the PSW anything.

In an interview, RPN #105 indicated that on the identified date, in the morning, PSW #104 asked the RPN if resident #003 had the identified treatment because they complained of pain. The RPN told the PSW that the resident was to have the identified treatment and they will administer to the resident. The resident was still in the room, and the RPN did not go to see the resident. They administered the treatment when PSW wheeled the resident out of the room, but RPN did not recall what time. RPN #105 stated the treatment had fair effect as the resident complained of pain again after a few hours. The RPN acknowledged that the identified treatment was not effective but they did not assess the resident as they noticed PSW #104 told the RPN in charge that resident had pain and they gave a different treatment to PSW #104 to apply to the resident's body part. The RPN stated they did not assess the resident for pain at that time using the identified tool for assessing resident with cognitive impairment.

A review of the resident's identified record indicated that the resident was not assessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose in their electronic documentation, until late that day, when a change of condition was identified.

An interview with NM-C indicated when the resident complained of pain despite having received an identified treatment, the resident should be assessed by the registered staff using the identified tool designed for resident with cognitive impairment and the staff should review whether the identified treatment should be revised. The NM-C stated that team identified a gap in the area of pain assessment regarding resident #003, when they held a post incident huddle, and provided training to staff immediately.

In an interview, DON acknowledged that on the identified date, resident #003 was not

assessed for pain by registered staff when they complained of pain despite having received regular treatment, using the tool they have specifically designed for assessing discomfort of resident with cognitive impairment. [s. 52. (2)]

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.