Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: September 21, 2023	
Inspection Number: 2023-1547-0004	
Inspection Type: Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Fudger House, Toronto	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.10.06 14:36:51 -04'00'
Additional Inspector(s) Trudy Rojas-Silva (000759)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 23, 24, 25, 28, 2023.

The following intake(s) were inspected:
· Intake: #00020777 Critical Incident (CI) M#524-000002-23 related to improper transfer resulting in injuries.
· Intake: #00085254 (CI #M524-000006-23) related to care and care services.
· Intake: #00094159 (CI #M524-000014-23) related to falls resulting in injuries.

The following intake was completed in this inspection:
· Intake: #00087140 (CI #M524-000007-23) related to a fall resulting in an injury.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of resident #003's care collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
The Occupational Therapist (OT) assessed resident #003 and recommended use of a fall intervention after the resident experienced a fall.

The recommended fall intervention was not applied as per resident's care plan during the onsite inspection.

A Registered Practical Nurse (RPN) and Personal Support Worker (PSW) both verified that resident #003 did not have the fall intervention in use after they fell. A Registered Nurse (RN) also verified that the use of fall intervention had not been implemented as they were not aware of the intervention.

Failure to collaborate with each other in the implementation of the fall intervention put resident #003 at risk for further injury.

Sources: Resident #003's clinical records, CI #M524-000014-23, observations, interview with RN #102 and other relevant staff.
[000759]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in resident #003's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

Resident #003's care plan stated that staff should check for incontinence at an identified frequency.

During the onsite inspection, the inspector observed that the care plan frequency was not being followed as indicated in the resident's care plan.

A PSW confirmed the inspector's observations and acknowledged that care was not provided according to the resident's plan of care.

Staff's failure to follow the plan of care put the resident at risk for possible skin break down.

Sources: Resident #003's care plan, observations, interview with PSW #107 and other relevant staff. [000759]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Conduct, at minimum, an audit of one mechanical lift transfer performed by PSW #103 on each shift worked for a period of three weeks following the service of this order.
2. Maintain a record of the audits, including the dates, who conducted the audits, staff and residents audited, results of audits and actions taken in response to the audit findings

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

Summary and Rationale
CI #M524-000002-23, was submitted to the Director related to improper transfer of resident #001 by PSW #103 resulting in a significant injury.

Resident #001's care plan indicated that they required assistance by two plus staff with the aid of a mechanical device for transferring.

On an identified date, a unit Nurse Manager (NM) provided a review of policy on resident transfers using mechanical devices lift with all staff on the unit including PSW #103. A week later, PSW #103 acknowledged that they had transferred resident #001 alone, using a mechanical device which resulted

in the resident being injured.

The PSW acknowledged that they transferred the resident by themselves from one location to another using the mechanical device.

The Director of Care (DOC) acknowledged that PSW #103 had more than one encounter in using mechanical devices by themselves, and that training, re-education, and disciplinary actions were taken.

Failure to use safe transferring and positioning devices or techniques put residents at risk for injuries.

Sources: Resident #001's electronic health records, the home's investigation notes, interview with PSW #103 and others.
[698]

This order must be complied with by November 2, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.