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
Oct 22, 2018	2018_753699_0006	004500-18, 006450-18	Critical Incident System

Licensee/Titulaire de permis

Ukrainian Home for the Aged
767 Royal York Rd. TORONTO ON M8Y 2T3

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

Ivan Franko Home (Etobicoke)
767 Royal York Road TORONTO ON M8Y 2T3

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

PRAVEENA SITTAMPALAM (699), IVY LAM (646)

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): September 26, 28, October 1, 2, 3, 2018.

The following Critical Incident intakes were inspected during this inspection: Log #004500-18 (CIS #C530-000003-18) and Log #006450-18 (C530-000004-18) related to incidents causing injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Personal Support Workers (PSW), Physiotherapist (PT), and residents.

During the course of the inspection, the inspectors observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The Ministry of Health and Long-Term Care (MOHLTC) received a Critical Incident system (CIS) report on a specified date indicating that resident #002 had a fall on a specific date, was transferred to the hospital on the same day, and admitted with an injury.

Review of resident #002's written plan of care, showed resident #002 was at a specified risk for falls. Fall prevention interventions for the resident included to ensure call bell was available for the resident, checking the resident every hour to ensure safety, ensure the environment was free of clutter, encourage the resident to use the walker at all times and use brakes when resident is sitting on the walker.

Interviews with Personal Support Workers (PSWs) #105 and #107, Registered Nurse (RN) #106, the physiotherapist (PT), and the Director of Care (DOC) stated that the resident was able to ambulate with walker with supervision prior to the fall on the aboved mentioned specified date. PSWs #105 and #107, RN #106, PT, and the DOC further stated that after resident #002 returned from the hospital, the resident required an increased level of assistance with many activities of daily living (ADL).

Interviews with PSWs #105 and #107, who worked regularly with resident #002, and RN #106, indicated that the resident was provided with a falls prevention and management intervention in the evening on one side of the bed as a fall prevention intervention. PSWs #105 and #107 stated that resident #002 was provided another falls prevention and management device after they had returned from the hospital.

Review of the nursing progress notes, indicated that resident #002 had the above mentioned falls prevention and management device in place.

Review of the resident's care plan indicated that the resident's transferring interventions were changed. Falls interventions were updated to include the fall with a specific injury. The falls prevention and management interventions mentioned above were not included in the written plan of care.

Interview with the DOC indicated that they recalled that resident #002 had the above mentioned falls prevention and management interventions in place in the evening when the resident was in bed, but the interventions were not included in the care plan. The DOC further stated that the interventions the PSWs recalled were true, and that the written plan of care was not revised to include them when resident #002's care needs changed after return from the hospital. [s. 6. (10) (b)]

2. The MOHLTC received a CIS report on a specified date indicating that resident #001 had sustained a fall on a specific date and was transferred to hospital with a specified suspected injury on the same day.

Review of resident #001's progress notes showed that resident had an unwitnessed fall. Resident #001 was assessed and found to have severe pain to a specific area, and was transferred to hospital for further assessment. The resident returned to the home three days later. Review of consultation/discharge summary notes from the hospital revealed that the resident was diagnosed with an specific injury. It was decided that a particular care approach would be undertaken and that the resident was not ambulatory.

Review of resident #001's documentation survey report for a specific month revealed that prior to the fall, resident #001 required a specified level of assistance from staff. After the fall the resident required and increased level of assistance with ADLs.

In an interview with RN #103, they stated resident #001 was able to get up with assistance prior to hospitalization however when they returned from hospital, they required an increased level of assistance and a requiring specific approach to care. RN #103 stated that staff can check resident care needs documented in the care plans. RN #103 could not recall if resident's change in care was documented in the care plan.

Review of resident #001's last care plan indicated that resident #001 was able to turn in bed and get in/out with some help, and required one person assistance with toileting and dressing. Further review of the care plan did not indicate that resident #001 required a specific care approach or was bedridden after returning from hospital.

In an interview with DOC #102, they stated that resident #001 required and increased level of assistance post hospitalization. DOC #102 stated that the care plan should have been updated with resident's new care needs when resident #001 returned from the hospital. [s. 6. (10) (b)]

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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol procedure, strategy or system instituted or otherwise put in place was complied with.

The MOHLTC received a CIS report on a specified date indicating that resident #001 had sustained a fall on a specific date and was transferred to hospital with a specified suspected injury on the same day.

Review of resident #001's progress notes showed that resident had an unwitnessed fall. Resident #001 was assessed and found to have severe pain to a specific area, and was transferred to hospital for further assessment. The resident returned to the home three days later. Review of consultation/discharge summary notes from the hospital revealed that the resident was diagnosed with an specific injury. It was decided that a particular care approach would be undertaken and that the resident was not ambulatory.

Review of home's policy titled Falls Prevention and Management, SOP: NM-I-258, last revision December 2016, under post fall management indicated that the MOHLTC was to be notified verbally within one business day and full report within 10 days of becoming aware of the incident if resident is taken to hospital.

In an interview with DOC #102, they stated it is the home's expectation that an incident that caused injury to a resident that resulted in significant change is reported to the MOHLTC within one business day. DOC #102 acknowledged that the CIS report submitted for resident #001 was not reported within one business day of the incident and did not comply with the above mentioned policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The MOHLTC received a CIS report on a specific date indicating that resident #002 had a fall on a specific date, was transferred to the hospital on the same day, and admitted with an injury.

Review of the home's incident report and resident #002's progress notes showed the resident had a fall, and was transferred to the hospital.

Review of resident #002's progress notes, showed the resident had been admitted to the hospital with a diagnosis of a specific injury. Review of the resident's progress notes and hospital discharge notes showed the resident had surgery on a specific date related to the injury and returned to the home on a specific date.

Review of home's policy titled Falls Prevention and Management, SOP: NM-I-258, last revision December 2016, showed for post fall management, the home is to notify the MOHLTC verbally within one business day and full report within 10 days of becoming aware of the incident if resident is taken to hospital.

Interviews with PSWs #105 and 107, RN #106, the physiotherapist (PT), and the Director of Care (DOC) stated that the resident was able to ambulate with walker with supervision prior to the fall. PSWs #105 and 107, RN #106, PT, and the DOC further stated that resident #002 required and increased level of assistance with ADLs after they had returned from the hospital from the fall.

Interview with the RAI Coordinator and the DOC indicated that the CIS should have been submitted to the MOHLTC when the resident was admitted to the hospital and that the home did not report the incident within the abovementioned specified timeframe as per the MOHLTC regulations. [s. 107. (3)]

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Issued on this 16th day of November, 2018

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

Original report signed by the inspector.