Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Sep 13, 2019	2019_749653_0021	004232-18, 007594-18, 018042-18, 022988-18, 029412-18, 002237-19, 002357-19, 011218-19	Critical Incident System

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

ROMELA VILLASPIR (653), JADY NUGENT (734)

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): July 22, 23, 24, 25, 26, 29, 30, 31, and August 1, 2, 6, 7, 8, 2019.

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

CIS intakes related to falls:
Log #(s): 004232-18, 022988-18, 029412-18, 002237-19, 002357-19, 011218-19.

CIS intakes related to staff to resident abuse:
Log #(s): 007594-18, 018042-18.

During the course of the inspection, the inspectors conducted observations of resident care provision, staff and resident interactions, reviewed clinical health records, staff training records, staffing schedules, staff employment records, the home's Critical Incidents (CI) binder, and internal investigation records.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), PSW Student, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Nurse Managers (NMs), Physiotherapist (PT), Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

A Voluntary Plan of Correction related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in this CIS inspection report #2019_749653_0021 will be issued under concurrent complaint inspection report #2019_749653_0020.

A Voluntary Plan of Correction related to r. 101 (2) of the O. Reg. 79/10, identified in this CIS inspection report #2019_749653_0021 will be issued under concurrent complaint inspection report #2019_749653_0020.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

1 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. 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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee had 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): An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident’s health condition.

The home submitted a Critical Incident Report (CIR) to the Director for 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. The CIR indicated on an identified date and time, resident #007 had an unwitnessed fall and was transferred to the hospital for further assessment.

A review of progress notes indicated resident #007 was found lying on the floor, at which time they had sustained an alteration in skin integrity and was transferred to the hospital due to complaint of severe discomfort. Three days following the fall incident, the home was informed by the hospital that resident #007 had sustained an injury. The resident returned to the home with a significant change in their health status. The CIR was submitted to the Director three days after the hospital had confirmed resident #007's injury that was sustained from the fall incident in the home.

An interview with Registered Practical Nurse (RPN) #123 indicated it was the responsibility of the Nurse Manager (NM) or the Director of Care (DOC) to submit the CIR to the Ministry of Long-Term Care (MLTC). Furthermore, RPN#123 stated that based on the timelines above, the submission would have been considered a late report to the MLTC.

During an interview, the DOC acknowledged that based on the legislated reporting requirements, the CIR was submitted late. [s. 107. (3) 4.]

2. The home submitted a CIR to the Director for 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. The CIR indicated on an identified date and time, resident #015 had an unwitnessed fall and was found on the floor beside their bed. The resident stated they slid to the floor, and the RPN sent them to the hospital for further assessment.

A review of resident #015's progress note indicated the Personal Support Woker (PSW) staff reported to the Registered Nurse (RN) that the resident had an unwitnessed fall in their bedroom. The RN carried out the post fall assessment and the resident complained of discomfort and was sent to the hospital. Further review of resident #015's progress note indicated RPN #100 received an update from the hospital the following day, indicating the resident was admitted with an injury.

During an interview, the DOC acknowledged the above mentioned information from record reviews and staff interviews, and that the home failed to ensure that the Director was informed of the incident in the home involving resident #015, no later than one business day after the occurrence of the incident. [s. 107. (3) 4.]

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 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): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.