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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: January 05, 2024

Inspection Number: 2023-1498-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Royal Canadian Legion District 'D' Care Centres

Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto

Lead Inspector	**Inspector Digital Signature**
Vernon Abellera (741751)	Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2024.01.17 09:46:33 -05'00'

Additional Inspector(s)
Nicole Lemieux (721709)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 14-15, 18-21, 2023.

The following intake(s) were inspected:

- Intake: #00098122 - Follow-up #: 1 - Compliance Order (CO) #001/ 2023_1498_0002, O. Reg. 246/22 - s. 55 (2) (a) (ii), Compliance Due Date (CDD) November 8, 2023.
- Intake: #00098123 - Follow-up #: 1 - CO #002/ 2023_1498_0002, O. Reg. 246/22 - s. 55 (2) (b) (i), CDD November 8, 2023.
- Intake: #00098124 - Follow-up #: 1 - CO #003/ 2023_1498_0002, O. Reg. 246/22 - s. 55 (2) (b) (iv), CDD November 8, 2023.

- Intake related to complaint on physical abuse and housekeeping.
- Intake related to Misuse/Misappropriation of resident's money.
- Intake related to Improper transfer resulting to injury.
- Intake related to Fall resulting to injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1498-0002 related to O. Reg. 246/22, s. 55 (2) (a) (ii) inspected by Vernon Abellera (741751)

Order #002 from Inspection #2023-1498-0002 related to O. Reg. 246/22, s. 55 (2) (b) (i) inspected by Vernon Abellera (741751)

Order #003 from Inspection #2023-1498-0002 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Vernon Abellera (741751)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale

A Critical Incident Report (CIR) was submitted to the Director for a fall that lead to injury for a resident which resulted in a significant change in status. Progress notes, multiple physiotherapy referrals, and care plan indicated that the resident was to be utilizing equipment as a fall's prevention intervention. Additionally, progress notes and multiple physiotherapy referrals identified that the resident was to use falls prevention equipment.

Observations of the resident were conducted. The resident was seen standing in their room self-transferring without the appropriate falls interventions in place as outlined in their written plan of care. A Registered Practical Nurse (RPN) was notified and confirmed that the resident did not have the appropriate fall's prevention interventions in place.

Further discussion with a Personal Support Worker (PSW), another RPN and

Physiotherapist (PT) confirmed that the resident was to have fall prevention interventions applied at all times.

Failing to ensure that the resident's fall prevention interventions were in place, as directed in the written plan of care, put the resident at risk for a falls.

Sources: Observations, resident's clinical records, interviews with multiple staff. [721709]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The license failed to ensure that a resident's care plan was revised when the resident's care needs changed, and the care set out in the plan was no longer necessary.

Rationale

A Critical Incident Report (CIR) was submitted to the Director for a fall that resulted in injury to a resident which caused a significant change in their status. Progress notes and multiple physiotherapy referrals indicated that the resident was to use fall

prevention interventions. Additionally, the resident's written care plan noted for staff to encourage the resident to use specific mobility equipment however upon return from hospital the resident's status changed and the resident required the use of different equipment for mobility.

During the inspection, it was identified that fall prevention interventions were not utilized as directed in the resident's written plan of care. The Inspector and RPN reviewed the resident's written care plan simultaneously and noted that the fall prevention equipment and intervention were not documented in the resident's written care plan. Additionally, the previous interventions for mobility were documented as interventions in the resident's written care plan. The RPN and a PSW confirmed that it was unsafe to use the previous mobility interventions since their return from hospital and this was no longer an updated intervention.

Further discussion with additional staff members including a Personal Support Worker (PSW), RPN and PT confirmed that the resident was to have the fall prevention intervention in place at all times. The RPN and PT confirmed that it was the responsibility for Registered Nursing staff to update the resident's written care plan with both new and discontinued interventions.

Failing to ensure that the resident's written care plan was revised with all changes put the resident at an increased safety and falls risk as there was unclear direction related to the use of various falls interventions.

Sources: Observations, resident's clinical records, interviews with multiple staff. [721709]