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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Nov 5, 2018	2018_644507_0021	024117-17, 027183-18	Complaint

Licensee/Titulaire de permis

Don Mills Foundation for Seniors
1 Overland Drive TORONTO ON M3C 2C3

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

Thompson House
1 Overland Drive NORTH YORK ON M3C 2C3

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 15, 17 and 18, 2018.

The following complaints were inspected concurrently with this inspection:
#024117-17 was related to responsive behaviour management and alleged staff to resident abuse, and
#027183-18 was related to falls prevention and management, and dealing with complaints.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), residents, family members and substitute decision-makers (SDM).

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in regard to resident #012's frequent falls and falls prevention management.

In an interview, resident #012's substitute decision-maker (SDM) stated that resident #012 had a number of falls in the past six months, and the SDM had concerns of the falls prevention management for the resident.

Review of the progress notes for resident #012 for a period of six months indicated that the resident had a total of 12 falls on identified dates.

Review of the Post Fall Assessments on PointClickCare (PCC), indicated that a post-fall assessment was completed on 10 of the above mentioned identified dates.

Review of the home's policy titled, "Fall Prevention and Management Program" policy #N007-013, effective March 2014, stated that when a resident has fallen, registered staff to complete a post fall assessment on PCC with input from all disciplines.

In interviews, staff #105 and #109 stated that a post fall assessment should be completed by registered staff when a resident has fallen. Staff #105 acknowledged the post fall assessments were not completed for resident #012 after the resident had fallen on two of the above mentioned identified dates.

B) Resident #013 was selected as a result of non-compliance identified with resident #012.

Review of the progress notes for resident #013 indicated that the resident had two falls on an identified date. Review of the Post Fall Assessments on PCC indicated that post-fall assessments were not completed for the above mentioned falls. Staff #105 acknowledged the post fall assessments were not completed for resident #013 when the resident had fallen on the above mentioned identified date. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for fall, to be implemented voluntarily.

WN #2: 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 an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

In accordance with O. Reg. 79/10, s. 107 (7), "significant changes" means a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A) A complaint was received by the MOHLTC on an identified date in regard to resident #012's frequent falls and falls prevention management.

Review of the progress notes of resident #012 indicated that the resident had a fall on an identified date. Resident #012 was sent to the hospital for further assessment. The resident returned to the home from the hospital the next day after receiving interventions in the hospital.

Review of the web-site LTC homes.net indicated the home did not submit a Critical Incident Report (CIS) to the Director related to the above mentioned significant changes of resident #012's health condition after the resident had a fall on the above mentioned identified date. It was confirmed during an interview with staff #109.

B) Resident #013 was selected as a result of non-compliance identified with resident #012.

Review of the progress notes for resident #013 indicated that the resident had two falls on an identified date. The resident was sent to the hospital approximately two hours after the second fall. The resident returned to the home five days later after receiving interventions in the hospital.

Review of the web-site LTC homes.net indicated the home did not submit a CIS to the Director related to the above mentioned significant changes of resident #013's health

condition after the resident fell on the above mentioned identified date. It was confirmed during an interview with staff #109.

C) Resident #014 was selected as a result of non-compliance identified with resident #012.

Review of the progress notes for resident #014 indicated that the resident had a fall on an identified date. The resident was sent to the hospital for further assessment two days later because of specific health condition. Resident #014 returned to the home six days later after receiving interventions in the hospital.

Review of the web-site LTC homes.net indicated the home did not submit a CIS to the Director related to the above mentioned significant changes of resident #014's health condition after the resident's fall occurred on the above mentioned identified date. It was confirmed during an interview with staff #109. [s. 107. (3)]

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 an incident that causes an injury to a resident for which the resident is taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required under subsection, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the falls prevention and management program were implemented in the home.

Review of the home's policy titled, "Fall Prevention and Management Program" policy #N007-013, effective March 2014, stated that registered nursing staff to initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident was on anticoagulant therapy.

A complaint was received by the MOHLTC on an identified date in regard to resident #012's frequent falls and falls prevention management.

In an interview, resident #012's SDM stated that resident #012 had a number of falls in the past six months, and the SDM had concerns of the falls prevention management for the resident.

Review of the progress notes for resident #012 for a period of six months indicated that the resident had a total of 10 unwitnessed falls on the identified dates.

Review of health record for resident #012 indicated that HIR was not completed for six of the above mentioned unwitnessed falls

In an interview, staff #105 stated that HIR was not completed for resident #012 when the resident had unwitnessed falls on the above mentioned dates. [s. 48. (1) 1.]

Issued on this 19th day of November, 2018

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

Original report signed by the inspector.