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

Public Copy/Copie du public

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_0020	006996-18, 021544-18, 021770-18	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 10, 11, 12 and 15, 2018.

**The following complaints were inspected concurrently with this inspection:
#006996-18 was related to an injury to a resident with no known cause, and
#021544-18 was related to improper transfer technique of a resident.**

**The following Critical Incident Report (CIS) was inspected concurrently with this inspection:
#021770-18 (CIS #C573-000009-18) was related to improper transfer technique of a resident.**

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), Registered Dietitian (RD), 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:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long-Term care (MOHLTC) received a complaint on an identified date in regard to improper transfer technique by staff which caused injuries to resident #001.

In an interview, resident #001's substitute decision-maker (SDM) stated that on an identified date, resident #001 sustained injuries due to improper transfer technique of staff.

Resident #001 was not interviewable.

Review of an identified Critical Incident System (CIS) report submitted to the MOHLTC the day after the incident occurred and the progress notes for resident #001 indicated that on an identified date at an identified time, an identified staff finished providing care to the resident and left the resident unattended. The resident fell when the staff went to get the mobility device which was placed outside the room. Upon assessment, injuries were noted. The resident was sent to the hospital for further assessment.

Review of the written plan of care completed six weeks prior to the above mentioned date for resident #001 indicated that the resident required supervision by staff to prevent falls.

In an interview, staff #101 stated that on the above mentioned identified date, staff #101 provided care to resident #001. The resident required a two-person transfer, and the resident's mobility device was placed outside the resident's room. Staff #101 assisted the resident to sit up, then went to fetch the mobility device and asked another staff for assistance to transfer the resident. While staff #101 was at the doorway of the resident's room, resident #001 fell onto the floor.

In an interview, staff #109 stated that resident #001 should not have left unattended during transfer. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home was a safe and secure environment for its residents.

The MOHLTC received a complaint on an identified date in regard to resident #001 sustaining an injury with no known cause.

In an interview, resident #001's SDM stated that on an identified date, resident #001 sustained an injury. It took a couple of months and two different medications for the injury to heal.

Resident #001 was not interviewable.

Review of resident #001's Achieva physiotherapy quarterly re-assessment completed two weeks prior indicated that the resident's range of motion and voluntary movement were restricted.

Review of the Resident Assessment Instrument - Mini Data Set (RAI-MDS) quarterly review assessment completed two weeks prior for resident #001 indicated that the resident required assistance and two persons physical assist for most of the activities of daily living (ADL).

Review of the progress notes for resident #001 indicated the resident's injury took approximately two weeks and three medications to heal.

In an interview, staff #108 stated that on an identified date and at an identified time, staff #106 and #108 noticed an injury on resident #001. Staff #106 applied treatment to the

injury. Then staff #108 provided care to the resident.

In an interview, staff #106 stated that on an identified date and at an identified time, staff #108 called and stated there was an injury on resident #001. Staff #106 went to assess, and noticed the injury and treatment was provided.

Staff #106 and #108 told the inspector that they could not remember the details, including the location of the injury, as the event occurred a long time ago.

In an interview, staff #109 stated that the home was not able to determine the cause of the injury after conducting the internal investigation of resident #001's injury. The home engaged a third party to investigate the matter further.

Review of the private investigator's report dated two months after the incident occurred, the private investigator stated that "concludes based on a balance of probabilities that the injury to the resident on or about the above mentioned identified date, was the result of a non-intentional act which occurred at some point during the course of care".

In an interview, staff #109 stated that when staff #109 assessed resident #001's injury four days after the discovery of the injury, did not think that the injury was caused by the resident themselves. It was possible the injury was caused by one of the equipment as resident #001's SDM suspected. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) The MOHLTC received a complaint on an identified date in regard to resident #001 sustaining an injury with no known cause.

In an interview, resident #001's SDM stated that on an identified date, resident #001 sustained an injury. It took a couple of months and two different medications for the injury to heal.

Review of progress notes for a period of two weeks starting from the above mentioned identified date for resident #001 indicated that the resident sustained an injury of altered skin integrity. It took approximately two weeks and three medications for the altered skin integrity to heal.

Review of the electronic health record on PointClickCare (PCC) for resident #001 indicated there was no skin assessment completed by a registered staff relating to the resident's above mentioned altered skin integrity. This was confirmed by staff #109

during an interview.

B) Resident #004 was selected as a result of non-compliance identified with resident #001.

Review of the progress notes for resident #004 indicated that on an identified date, an altered skin integrity was noted.

Review of the electronic health record on PCC for resident #004 indicated there was no skin assessment completed by a registered staff relating to the resident's above mentioned altered skin integrity. This was confirmed by staff #109 during an interview.

C) Resident #005 was selected as a result of non-compliance identified with resident #001.

Review of the progress notes for resident #005 indicated that on an identified date, an altered skin integrity was noted.

Review of the electronic health record on PCC for resident #005 indicated there was no skin assessment completed by a registered staff relating to the resident's above mentioned altered skin integrity. This was confirmed by staff #109 during an interview. [s. 50. (2) (b) (i)]

2. The Licensee has failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A) The MOHLTC received a complaint on an identified date in regard to resident #001 sustaining an injury with no known cause.

In an interview, resident #001's SDM stated that on an identified date, resident #001 sustained an injury of altered skin integrity. It took a couple of months and two different medications for the altered skin integrity to heal.

Review of the progress notes for a period of two weeks starting from the above mentioned identified date for resident #001 indicated that the resident sustained an injury of altered skin integrity with unknown cause.

Review of the electronic health record on PCC for resident #001 indicated there was no nutritional assessment completed by a registered dietitian relating to the resident's above mentioned altered skin integrity. This was confirmed by staff #110 during an interview.

B) Resident #005 was selected as a result of non-compliance identified with resident #001.

Review of the progress notes for resident #005 indicated that on an identified date, an altered skin integrity was noted.

Review of the electronic health record on PCC for resident #005 indicated there was no nutritional assessment completed by a registered dietitian relating to the resident's above mentioned altered skin integrity. This was confirmed by staff #110 during an interview. [s. 50. (2) (b) (iii)]

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, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
a) receive a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and
b) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #001's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity were fully respected and promoted.

The MOHLTC received a complaint on an identified date in regard to resident #001 sustaining an injury with no known cause.

In an interview, resident #001's SDM stated that on an identified date, resident #001 was found by an identified staff with an injury. The SDM further stated that resident #001 expressed prior that the resident did not want certain staff to provide personal care.

Review of the most current written plan of care for resident #001 indicated that no certain staff to provide care for resident, and it was initiated two years prior.

In interviews, staff #106 and #108 stated that they were not aware resident #001 did not wish certain staff to provide care. Staff #108 stated certain staff have been providing personal care to the resident in average two nights per week since the resident's admission four years ago.

In an interview, staff #109 stated it was documented in resident #001's written plan of care that no certain staff to provide personal care, and staff should be aware of that. [s. 3. (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.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2018_644507_0020
Log No. / No de registre :	006996-18, 021544-18, 021770-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 5, 2018
Licensee / Titulaire de permis :	Don Mills Foundation for Seniors 1 Overland Drive, TORONTO, ON, M3C-2C3
LTC Home / Foyer de SLD :	Thompson House 1 Overland Drive, NORTH YORK, ON, M3C-2C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William Krever

To Don Mills Foundation for Seniors, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:
1) Ensure that for resident #001 and all other residents who require assistance with transferring; staff use safe transferring techniques to assist the resident.
2) Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to the resident's written plan of care.
3) Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the action required of the audit.

Grounds / Motifs :

1. The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long-Term care (MOHLTC) received a complaint on an identified date in regard to improper transfer technique by staff which caused injuries to resident #001.

In an interview, resident #001's substitute decision-maker (SDM) stated that on an identified date, resident #001 sustained injuries due to improper transfer technique of staff.

Resident #001 was not interviewable.

Review of an identified Critical Incident System (CIS) report submitted to the MOHLTC the day after the incident occurred and the progress notes for resident #001 indicated that on an identified date at an identified time, an identified staff finished providing care to the resident and left the resident unattended. The resident fell when the staff went to get the mobility device which was placed outside the room. Upon assessment, injuries were noted. The resident was sent to the hospital for further assessment.

Review of the written plan of care completed six weeks prior to the above mentioned date for resident #001 indicated that the resident required supervision by staff to prevent falls.

In an interview, staff #101 stated that on the above mentioned identified date, staff #101 provided care to resident #001. The resident required a two-person transfer, and the resident's mobility device was placed outside the resident's room. Staff #101 assisted the resident to sit up, then went to fetch the mobility device and asked another staff for assistance to transfer the resident. While staff #101 was at the doorway of the resident's room, resident #001 fell onto the floor.

In an interview, staff #109 stated that resident #001 should not have left unattended during transfer.

The severity of this non-compliance was identified as actual harm or risk, the scope was identified as isolated. Due to the severity of actual harm or risk a compliance order is warranted. (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG

Service Area Office /
Bureau régional de services : Toronto Service Area Office