Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2020	2020_644507_0005	001388-20, 001532-20	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): February 10 and 11, 2020.

The following intakes were inspected during this inspection:
Log #001388-20 related to personal support services and,
log #001532-20 related to injury with unknown cause.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Registered Nurses (RN), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) Coordinator and Recreationist.

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident health records and home records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director in regards to resident #001's significant change of health status as a result of an incident.

Review of the care plan for resident #001 completed approximately two months prior to the above mentioned incident indicated that the resident required a specified level of assistance (level A) for toileting. The same care plan also indicated that the resident required a specified mechanical lift (device A) with level A assistance for transfer, another specified mechanical lift (device B) to be used occasionally if resident's condition required.

Review of the CIS report and the progress notes of resident #001 indicated that on the date of the incident, the resident was found on the floor in their room. The resident was sent to the hospital for further assessment. Resident #001 returned to the home on the same day with injuries noted. Review of the hospital discharge summary indicated resident #001 sustained injuries and required interventions.

In an interview, staff #103 stated that on the identified date, at an approximate identified time, the resident requested assistance for toileting. Staff #103 provided an identified level of assistance (level B) in assisting the resident with transfer and toileting in the resident's room. During the toileting process, staff #103 left the resident's room. When staff #103 returned to the resident's room, they found resident #001 lying on the floor. Staff #103 then called for help.

Staff #103 told the inspector that they noticed resident #001 was not able to be assisted with device A for transferring from bed to washroom one week prior to the above mentioned incident. Staff #103 decided to assist the resident to be toileted in the resident's room without informing the registered staff. Staff #103 stated that on the day the above mentioned incident occurred was the third time they assisted the resident toileting in the room. Staff #103 also stated that they were aware resident #001 required level A assistance during toileting, but on the above mentioned identified date, staff #103 provided level B assistance to the resident. In addition, staff #103 stated they were aware of the home's policy of providing level A assistance to residents when transferring residents with a mechanical lift; however, they have transferred residents with mechanical lift with level B assistance.

In an interview, staff #101 stated that on the above mentioned identified date, at an identified approximate time, they were alerted to go to resident #001's room. Upon

arrival, staff #101 observed resident #001 lying on the floor. Staff #101 assessed the resident and sent the resident to the hospital for further assessment. Staff #101 further stated that they did not receive any reports from staff members that resident #001 was not able to tolerate the transfer with device A from bed to the washroom during the week prior to the above mentioned incident.

In an interview, staff #102 stated that staff #103 should follow the home's policy in performing the transfer of a resident with a mechanical lift with level A assistance. In addition, staff #103 should follow resident #001's care plan by providing level A assistance, not level B assistance, to the resident with toileting on the above mentioned identified date. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2020_644507_0005
Log No. / No de registre :	001388-20, 001532-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 14, 2020
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 :	Bill Trenbeth

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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.
Specifically the licensee must:
1) Ensure that resident #001, and all other residents who require assistance with transfer with a mechanical lift, are provided with the appropriate level of assistance and transfer device as per their plan of care;
2) Ensure that resident #001, and all other residents who require assistance with toileting, are provided with the appropriate level of assistance as per their plan of care;
3) Develop and implement an auditing system to ensure staff are providing care to residents as set out in the plan of care related to transfer and toileting; and
4) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director in regards to resident #001's significant change of health status as a result of an incident.

Review of the care plan for resident #001 completed approximately two months prior to the above mentioned incident indicated that the resident required a specified level of assistance (level A) for toileting. The same care plan also indicated that the resident required a specified mechanical lift (device A) with level A assistance for transfer, another specified mechanical lift (device B) to be used occasionally if resident's condition required.

Review of the CIS report and the progress notes of resident #001 indicated that on the date of the incident, the resident was found on the floor in their room. The resident was sent to the hospital for further assessment. Resident #001 returned to the home on the same day with injuries noted. Review of the hospital discharge summary indicated resident #001 sustained injuries and required interventions.

In an interview, staff #103 stated that on the identified date, at an approximate identified time, the resident requested assistance for toileting. Staff #103 provided an identified level of assistance (level B) in assisting the resident with transfer and toileting in the resident's room. During the toileting process, staff #103 left the resident's room. When staff #103 returned to the resident's room, they found resident #001 lying on the floor. Staff #103 then called for help.

Staff #103 told the inspector that they noticed resident #001 was not able to be assisted with device A for transferring from bed to washroom one week prior to the above mentioned incident. Staff #103 decided to assist the resident to be toileted in the resident's room without informing the registered staff. Staff #103 stated that on the day the above mentioned incident occurred was the third time they assisted the resident toileting in the room. Staff #103 also stated that they were aware resident #001 required level A assistance during toileting, but on the above mentioned identified date, staff #103 provided level B assistance to the resident. In addition, staff #103 stated they were aware of the home's policy of providing level A assistance to residents when transferring residents with a mechanical lift; however, they have transferred residents with mechanical lift with level B assistance.

In an interview, staff #101 stated that on the above mentioned identified date, at an identified approximate time, they were alerted to go to resident #001's room. Upon arrival, staff #101 observed resident #001 lying on the floor. Staff #101 assessed the resident and sent the resident to the hospital for further assessment. Staff #101 further stated that they did not receive any reports from staff members that resident #001 was not able to tolerate the transfer with device A from bed to the washroom during the week prior to the above mentioned incident.

In an interview, staff #102 stated that staff #103 should follow the home's policy in performing the transfer of a resident with a mechanical lift with level A assistance. In addition, staff #103 should follow resident #001's care plan by providing level A assistance, not level B assistance, to the resident with toileting on the above mentioned identified date.

The severity of this issue was determined to be a level 3 as there was actual risk/ harm to resident #001. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 3 compliance history as there were two previous noncompliance (written notification and voluntary plan of correction) to the same subsection issued in the last 36 months which included:
- inspection report #2019_769646_0014 issued on October 7, 2019, and
- inspection report #2019_767643_0018 issued on June 12, 2019.

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2020

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 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 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 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 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 14th day of February, 2020

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