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

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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
Feb 12, 2019	2018_754727_0012	001973-18, 005739-18, 007862-18, 008404-18, 015869-18, 027133-18	Critical Incident System

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

JOANNA WHITE (727), JULIENNE NGONLOGA (502), ORALDEEN BROWN (698)

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): December 14, 17, 18, 19, 20, 21, 28, 2018, January 2, 3, 4, 7, and 8, 2019.

During this inspection the following Critical Incident System (CIS) intakes were inspected: Log #027133-18, CIS 027133-18 related to medication, Log #005739-18, CIS #2947-000052-18, Log #001973-18, CIS # 2947-000005-18 and Log #015869-18, CIS #2947-000037-18 were related to falls.
The following follow up inspection was conducted: Log #008404-18.

During the course of the inspection, the inspector(s) spoke with with the Executive Director, Director of Resident Care (DRC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist, and residents.

During the course of the inspection, the inspectors conducted observations in resident areas, observed staff to resident interaction, observed care delivery processes including the mobility and transfer of residents, reviewed residents' health records, staff schedules, policies and procedures and staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_525596_0002	698

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1.The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Review of the critical incident system (CIS) report that the home submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated that on a specified date resident #006 sustained a fall with injuries.

Record review of resident #006's health records indicated the resident had physical and cognitive impairments, and required extensive one person assistance with activities of daily living. Resident #006 was at risk for falls.

The care plan indicated fall prevention interventions that specified staff to activate wheelchair alarm when resident is in tilt wheelchair.

Record review of progress notes indicated the resident had a total of nine falls over a period of ten months.

Observations on a specified date by Inspector #727 identified the resident folding laundry in the activity room with the tilt wheelchair reclined moderately backwards. Further observations on two subsequent specified dates showed resident to be sitting upright in their tilt wheelchair.

Interviews with staff regarding their understanding of tilting the wheelchair when the resident was seated, resulted in the following responses:
-RPN #106 responded that the wheelchair had to be tilted based on your judgement,
-RPN #105 and PSW # 113 reported the wheelchair should be brought back a little bit,
-PSW #112 reported the wheelchair should be in normal position.

Interview with the home's Falls lead #110 acknowledged the information indicted in resident #006's care plan was incomplete, as it was missing frequency and not specific.

Interview with the Director of Care (DOC) acknowledged that resident #006's care plan did not set out clear directions to staff and others who provide direct care to the resident.

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

Review of a CIS report that the home submitted to the MOHLTC indicated that on a specified date resident #007 had an incident in the washroom, complained of pain and was transported to hospital.

Record view of resident #007's health records indicated they were hospitalized due to sustaining an injury, given a particular diagnosis, and underwent a specified procedure. The resident was readmitted to home after undergoing the specified procedure.

Further review of resident #007's health records revealed the resident had physical and cognitive impairments and required extensive assistance with one person assistance with activities of daily living. Resident #007 was at risk for falls.

Review of the progress notes over a period of six months indicated the resident had a total of six falls.

The progress notes on a specified date indicated physiotherapist #111 recommended a wheelchair alarm and bed alarm as fall prevention interventions for resident #007.

The care plan indicated fall prevention interventions that specified staff to ensure alarm is applied when the resident is in bed.

Interview with the Falls lead #110 reported that all new admissions would be provided a bed with an alarm device.

Review of post fall assessment notes on a specified date, identified that resident #007's bed alarm device was not turned on when they were in bed on the above mentioned specified date.

Interviews with RN # 116 and PSW #117 reported that resident #007's bed alarm was not turned on when the incident occurred on the above mentioned specified date. PSW #117 reported hearing the resident's voice calling for help and not hearing the sound of their bed alarm.

Interview with the DOC indicated staff are expected to follow the plan of care when providing care for residents

3.The licensee has failed to ensure that different approaches were considered in the revision of the plan of care, if the plan of care is being revised because care set out in the plan had not been effective.

Review of a CIS report that the home submitted to the MOHLTC indicated that on a specified date, resident #008 had a fall and their condition deteriorated. They were transported to hospital for assessment and treatment. The resident was re-admitted to the home 10 days later.

Record review of resident #008's health records revealed the resident had both physical and cognitive impairments and required total assistance by one person for their activities of daily living. Their post-falls assessment indicated the resident was at risk for falls

Review of the progress notes over a period of seven months indicated the resident had a total of twelve falls.

Review of resident #008's progress notes and post-fall assessments revealed that their falls continued to occur despite the interventions identified in the care plan.

Interviews with RPN #106, PSW #120 and falls lead #110 reported that resident #008 was at risk for falls, unsteady on their feet, and attempted to self-transfer from bed and chair, which contributed to their falls. These staff acknowledged the falls interventions were ineffective at preventing resident #008 from falls.

Interview with RPN #118 reported the home tried everything, however resident #008 would still fall.

Interview the home's falls lead #110 acknowledged that new interventions were not implemented for resident #008 over a period of four months

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 plan of care set out clear directions to staff and others who provided direct care to the resident,
- the care set out in the plan of care is provided to the resident as specified in the plan,
- different approaches are considered in the revision of the plan of care, if the plan of care is being revised because care set out in the plan had not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of a critical incident system CIS report that the home submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated that on a specified date resident #006 sustained a fall with injuries.

Record review of resident #006's health records indicated the resident had physical and cognitive impairments, and required extensive one person assistance with activities of daily living. Resident #006 was at risk for falls.

The care plan indicated fall prevention interventions that specified staff to activate wheelchair alarm when resident is in tilt wheelchair.

Record review of progress notes indicated the resident had a total of nine falls over a period of 10 months.

A review of the home's Falls Prevention Policy, revision date January 2015, stated that post falls assessment required registered staff to monitor Head Injury Routine (HIR) as per the schedule on the form post fall for signs of neurological changes, i.e. facial droop, behavioural changes, weakness on one side, etc. The HIR routine identified on the form is 15 minutes for the first hour, every 30 minutes for the second hour, every hour for three hours, every two hours for eight hours, and every four hours for twelve hours or unless directed by the physician to cease monitoring.

A review of resident #006's HIR records on specified dates identified incomplete and

missing head injury documentation for the monitoring period after the fall.

An interview with the DOC stated that staff were expected to complete the HIR for resident #006 on the above mentioned dates at the appointed times for resident #006 and did not.

2. Review of a (CIS) report that the home submitted to the MOHLTC indicated that on a specified date resident #007 had an incident in the washroom, complained of pain and was transported to hospital.

Record view of resident #007's health records indicated they were hospitalized due to sustaining an injury, given a particular diagnosis, and underwent a specified procedure. The resident was readmitted to home after undergoing the specified procedure.

Further review of resident #007's health records revealed the resident had physical and cognitive impairments and required extensive assistance with one person assistance with activities of daily living. Resident #007 was at risk for falls.

Review of the progress notes over a period of six months indicated the resident had a total of six falls.

A review of the home's Falls Prevention Policy, revision date January 2015, stated that post falls assessment required registered staff to monitor Head Injury Routine (HIR) as per the schedule on the form post fall for signs of neurological changes, i.e. facial droop, behavioural changes, weakness on one side, etc. The HIR routine identified on the form is 15 minutes for the first hour, every 30 minutes for the second hour, every hour for three hours, every two hours for eight hours, and every four hours for twelve hours or unless directed by the physician to cease monitoring.

A review of resident #007's HIR records on specified dates identified incomplete and missing head injury documentation for the monitoring period after the fall.

An interview with the DOC stated that staff were expected to complete the HIR on the above mentioned dates at the appointed times for resident #007 and did not.

3. Review of CIS report that the home submitted to the MOHLTC indicated that on a specified date, resident #008 had a fall and their condition deteriorated.They were transported to hospital for assessment and treatment. The resident was re-admitted to

the home 10 days later.

Record review of resident #008's health records revealed the resident had both physical and cognitive impairments and required total assistance by one person for their activities of daily living. Their post-falls assessment indicated the resident was at risk for falls

Review of the progress notes over a period of seven months indicated the resident had a total of twelve falls.

A review of the home's Falls Prevention Policy, revision date January 2015, stated that post falls assessment requires registered staff to monitor Head Injury Routine (HIR) as per the schedule on the form post fall for signs of neurological changes, i.e. facial droop, behavioural changes, weakness on one side, etc. The HIR routine identified on the form is 15 minutes for the first hour, every 30 minutes for the second hour, every hour for three hours, every two hours for eight hours, and every four hours for twelve hours or unless directed by the physician to cease monitoring.

A review of resident #008's HIR records on specified dates identified incomplete and missing head injury documentation for the monitoring period after the fall.

An interview with the DOC stated that staff were expected to complete the HIR for resident #008 on the above mentioned dates at the appointed times for resident #008 and did not.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

Review of a CIS report that the home submitted to the MOHLTC indicated that on a specified date resident #001 received incorrect medication and was transported to hospital.

Record review of resident #001's health records indicated they were hospitalized and returned to home. Resident #001 required cueing and supervision and their medications were administered by the staff.

The care plan indicated that resident #001 had altered communication, inability to express emotion, listen and share information. The interventions identified in the care plan was to ensure speaker's face is in light and not standing in front of light source; face resident, and do not cover mouth when speaking to/ conversing with resident. Get resident's attention before beginning to speak to resident.

Review of resident #001's electronic Medication Administration Record (eMAR) for a specified month, revealed that a specified medication should be administered at 2000 hours (hrs).

Review of resident #005's eMAR for a specified month, revealed that four medications should be administered at 2000 hrs,

Interview with RPN #100 reported that they were not familiar with the residents and called out resident #005's name, however resident #001 responded by walking towards the medication cart. RPN #100 confirmed that resident #005's medication was administered to resident #001.

Interview with RN #103 reported that the medication incident was immediately reported

by RPN #100. RN #103 acknowledged that resident #001 was administered the medications that was prescribed to resident #005. As a result, resident #005 did not receive any of their 2000 hrsr medications on the specified date.

Review of the home's Medication Incident Report (MIR) for resident #005, revealed their prescribed medication was received an hour later than the scheduled time.

Review of the home's MIR for resident #001, revealed an incorrect dose of medication was administered.

A review of the home's Administering Medications Policy dated March 1,2006, revision January 11,2016, indicated that a thorough verification process must be completed before each medication is given, and administer medications as per physician's orders.

During an interview the DOC acknowledged that registered staff are expected to follow the medication administration policy, and College of Nurses Ontario (CNO) standards by conducting a resident verification before administering medications. The DOC further added that registered staff are accountable, they need to know the medication rights, are expected to make sure the resident is safe and to provide the medication and treatment to the right resident. The staff are expected to make sure the medication they give to residents is accurate.

The DOC stated that RPN #100 did not check the resident identification and it was their first day on the unit. Also the resident profile picture on the eMar should have been checked.

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

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Issued on this 20th day of February, 2019

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

Original report signed by the inspector.