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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 25, 2024	
Inspection Number: 2024-1431-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Friuli Long Term Care	
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature** Slavica Vucko Digitally signed by Slavica Vucko Date: 2024.03.27 11:14:09 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 11, 12, 13, 14, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00108705 – related to outbreaks
- Intake: #00110244 – related to a fall with injury

The following intake(s) were inspected in this complaint inspection:

- Intake: #00107797 – related to improper care
- Intake: #00109851 – related to a fall with injury

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

Resident Care and Support Services
Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

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.

Summary and Rationale

On a specified date resident #002 sustained a fall when staff transported them to provide personal care.

The home's Falls Prevention and Management policy indicated that the Nurse will assess the environment, before mobilizing the resident, for clues as to objects that may have struck the resident during the fall or caused the fall and conduct a thorough investigation of the fall incident, including all contributing factors.

The resident was assessed after the fall by registered staff. The sections in the Post

Fall Huddle form, related to outcomes of the post fall interdisciplinary discussion with interdisciplinary participants, and if the resident's care plan had been updated, were empty. The section regarding falls strategies put in place after the fall to prevent reoccurrence did not include any strategies.

The incident fall audit report was reviewed and signed by Assistant Director of Care (ADOC) and Director of Care (DOC). They confirmed that they did not observe the environment where the incident happened for safety, and they did not make sure that the missing sections in the Post Fall assessment were completed.

The environment safety was assessed by the OT (Occupational Therapist) two months after the fall. The OT recommended specific devices not to be used in the specified space due to floor safety issues.

Failure to complete an environmental assessment as part of a comprehensive post fall assessment placed resident at risk for injury due to unsafe flooring condition in a shower room.

Sources: observation, home's policy Falls Prevention and Management , VII-G-30.10, dated April 2023, interviews with home's staff.
[210]

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The home failed to ensure that the home was maintained in a safe condition, and in

a good state of repair.

Summary and Rationale

Resident #002 sustained a fall when assisted by staff with personal care on a specified date during transportation with a specific device at a specified location.

Observation of the incident location indicated uneven floor surface for safe transport with specific devices.

The home's staff confirmed unsafe finishing of the floor on one unit, for transport of residents utilizing specific devices.

Unsafe flooring conditions in specific areas of the home placed residents at risk for injury during transfers.

Sources: observation of floors in the building, resident #002's clinical record, interview with resident #002's family member and home's staff.
[210]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home has failed to ensure that the written description of the falls prevention and management program included relevant procedures and protocols for the referral of residents to specialized resources (Physiotherapist (PT) or OT) when there is a device involvement during a fall.

Summary and Rationale

Resident #002 sustained a fall from a specific device when a staff assisted with transport to provide personal care.

The home's policy Fall Prevention and Management indicated each member of the interprofessional team (Nurse, PT, OT, etc) will complete their respective assessments and discuss the appropriate interventions to mitigate the falls risk with the interprofessional care team. The policy did not include clear direction to staff on when an OT referral should be sent.

Registered staff sent referral to the PT for post fall assessment with no indication that a device was involved during the fall. The PT did not assess the device. Registered staff indicated that there was no description in the Falls Management policy when a referral should be sent to the OT for a device assessment after a fall from it.

Lack of clarify on what an OT referral should be sent placed resident #002 at risk of not receiving care based on their current needs.

Sources: home's policy Falls Prevention and Management VII-G-30.10 dated April 2023, resident #002 clinical record, interviews with the home's staff.
[210]