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 2, 2018	2018_751649_0018	008137-17, 025441-17, 025473-17, 028867-17, 000317-18, 007757-18, 007831-18	Complaint

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

JULIEANN HING (649), SUSAN SEMEREDY (501)

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): on September 14, 17, 18, 20, 21, 24, 25, 26, 28, and October 9, 2018.

The following intakes were inspected:
Complaint log #008137-17 related to allegations of no consent for new medication, concern about nail care and no shower/bath
Critical Incident system (CIS) #M596-000012-17 and complaint log #025473-17 related to improper care
CIS #M596-000014-17 and complaint log #000317-18 related to injury of unknown cause
CIS #M596-000012-18 and complaint log #007757-18 related to cause of injury unknown

This inspection was conducted concurrently with RQI report #2018_751649_0017. A Written Notification (WN) and Voluntary Plan of Correction (VPC), related to S.O. 2007 c.8 s. 6 (2), s. 6 (9), r. 131 (1) and a WN and Compliance order (CO) related to S.O. 2007 c.8 s. 19 (1) was identified in this inspection #2018_751649_0018 and has been issued in RQI report #2018_751649_0017, dated November 2, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse Manager (CNM), Manager of Resident Services, Physiotherapist (PT), Counsellor, registered nurses (RNs), registered practical nurses (RPNs), Resident Assessment Instrument - Minimum Data Set (RAI-MDS) back-up, personal support workers (PSWs), recreation services assistant (RSA), private caregivers, residents and family members.

During the course of the inspection the inspector(s) observed delivery of resident care and services, observed staff to resident interactions, reviewed resident's health records, reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) for resident #036 alleging inappropriate force during care, that resulted in the resident sustaining an injury.

A review of the resident's progress notes on an identified date indicated that they had complained of pain to an identified area. An assessment by the nurse was conducted and according to the documentation there was no redness, no hardness, no tenderness, no swelling, not hot to touch.

The nurse who documented the above entries was no longer working at the home and not available for an interview.

During an interview with PSW #123, who had worked with the resident on an identified date and had provided care to the resident along with the resident's private sitter told the inspector that the resident was screaming out in pain saying ouch somebody help me. The PSW stated they had not reported that the resident was having pain to the nurse as they were told by the resident's private sitter that the resident had pain on and off.

Further review of progress notes on an identified date states that the resident complained of pain while staff repositioned them and scheduled pain medication was administered.

During an interview with RPN #131, who worked the evening shift with the resident on an identified date and made the above entry stated they had not physically assessed the resident when the resident complained of pain while being repositioned by staff. When the RPN was asked if there was anything they would have done differently they stated that they should have been more careful in their assessment of the resident, not just relied on the resident's response when they denied pain, and should have called the registered nurse immediately and together completed an assessment of the resident.

During an interview with RN #119, they could not recall assessing the resident on the identified date and stated that if the resident was complaining of pain to an identified area an assessment should have been completed. RN #119 acknowledged there was no collaboration between themselves and RPN #131 in the assessment of the resident.

During interviews with DOC #101 and CNM #120, they confirmed that the staff did not collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other when the

resident had reported pain. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the MOHLTC alleging concern about resident #037's nail care and that bath/shower were not provided during an identified period. The complainant also reported that the resident's SDMs had not been notified about the administration of an identified medication.

Review of the physician's orders indicated the resident was prescribed an identified medication daily in the morning. The SDM consent box had not been checked on the physician order sheet and a review of progress notes did not indicate that consent had been obtained. According to a progress note on an identified date states that the resident was started on the identified medication.

Review of conference notes on an identified date indicated that the resident's SDMs were advised by the physician that new orders for medications will not be processed until they both have consented.

During interviews with DOC #101, RPN #121 and RN #137, they confirmed that the resident's SDM had not consented to the administration of an identified medication. [s. 6. (5)]

3. 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.

The home submitted Critical Incident System (CIS) report to the MOHLTC, according to this report, resident #026 had pain to an identified area and was sent to the hospital the following day and diagnosed with an injury.

Review of the home's investigation notes for the above incident indicated PSW #125 provided care to resident #026 on an identified date and although had another staff member help with transferring the resident back to bed after lunch, did not have any staff member help with changing their incontinent product or brief.

During an interview with PSW #125 they admitted that they were aware that resident #026's plan of care stated that the resident required two people for brief changes but stated "everybody was busy" and felt they could only ask for help with transferring. The PSW stated they were fairly new and everyone had told them resident #026 only required one person for changing their brief and providing care.

During an interview with PSW #126, they indicated they often would provide care to resident #026 alone but would always have two staff for transferring. During an interview with PSW #102, who was resident #026's primary care giver during the time period of the above incident, they indicated they would usually ask for help when changing resident #026's brief because of an identified condition. During an interview with RPN #121 who would sometimes help with transferring resident #026, they thought that the resident needed only one person for brief changes. Upon reading the written plan of care at the time of the incident, RPN #121 confirmed resident #026 needed two people for brief changes. During an interview with PSW #127 who is currently resident #026's primary care giver, they indicated they provided care alone for brief changes. Upon reading the current plan of care, PSW #127 stated that the plan of care indicated two people were needed for brief changes.

During an interview with RN #105 they stated that at the time of the incident, as well as currently, resident #026 had required and still requires two people for brief changes because of an identified condition and it is difficult to perform the care with only one person. During an interview with DOC #101, they confirmed that the staff did not follow the care set out in the plan of care as resident #026 required two people for incontinent brief changes. [s. 6. (7)]

4. The home submitted a CIS report related to improper care of resident #027. Review of a complaint received by the MOHLTC indicated that the resident was receiving improper care and was being neglected in regards to their toileting needs.

Review of the home's investigation notes indicated that PSW #125 provided care to resident #027 on an identified date. According to the PSW, they were aware that resident #027 required two people for all ADLs. According to the PSW, they changed the resident's incontinent product at the beginning of their shift and at the end of the shift. The PSW also stated that since they worked night shift on an identified unit, it was as "if they were working alone" and that some residents were very difficult to provide care for because of an identified condition.

During an interview with PSW #125, they admitted that they provided continence care for resident #027 on an identified date alone and was aware that the plan of care specified that two people were to provide such care.

During an interview with DOC #101 they acknowledged that resident #027 should have had two staff to change resident #027's incontinent brief and provide hygiene care. [s. 6. (7)]

5. A complaint was submitted to the MOHLTC for resident#036 alleging inappropriate force during care, that resulted in the resident sustaining an injury.

A review of the resident's care plan directed staff to observe for signs and symptoms associated with pain and to administer medication as per physician orders.

A review of the resident's MAR directed staff to give an identified scheduled pain medication three times a day.

A review of the progress notes on an identified date indicated that the resident complained of pain to an identified area and an assessment was completed. According to the documentation there was no redness, no hardness, no tenderness, no swelling, not hot to touch and had analgesia earlier.

Further review of progress notes indicated that the resident had a health condition according to their private sitter. The resident was assessed by the nurse and the physician was informed and ordered pain medication as needed (PRN) and an x-ray. According to documentation the resident health condition had improved and their pain had subsided, vitals checked and the resident was comfortable and resting in bed. The nurse later documented that the scheduled pain medication was held and the PRN pain medication was not administered to the resident, therefore no pain medication had been given to the resident when they had been observed in pain.

The nurse who documented the above entries was no longer working at the home and not available for an interview.

During an interview with PSW #123 who had worked with the resident on an identified date and had provided care to the resident along with the resident's private sitter told the inspector that the resident was screaming out in pain saying ouch somebody help me. The PSW told the inspector that they had not reported to the nurse that the resident was

having pain as they were told by the resident's private sitter that the resident had pain on and off.

During interviews with DOC #101 and CNM #120, they confirmed that the resident's plan of care had not been followed as PSW #123 should have immediately reported that the resident was having pain to the nurse and the scheduled pain medication should have been administered to the resident when they had reported pain on an identified date. [s. 6. (7)]

6. The licensee had failed to ensure that the staff who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

The home submitted a CIS report to the MOHLTC, according to this report, resident #026 had pain to an identified area and was sent to the hospital the following day and diagnosed with an injury.

During an interview with PSW #127 on an identified date they stated that they had only been assigned to provide care to resident #026 for about a month and since being reassigned had not checked resident #026's plan of care. As far as they were concerned, resident #026 had recovered from their injury and no longer needed two persons for changing their brief. The PSW told the inspector that they were aware that the resident was healed from their injury and not in pain. The PSW stated that in such cases, if they think they can handle a resident on their own, they go ahead and do so because the unit is so busy. Upon reviewing the above mentioned plan of care, they confirmed that two people were needed.

During an interview with RN #105 they stated that at the time of the incident, as well as currently, resident #026 had required and still requires two people for brief changes because of an identified condition and it is difficult to perform the care with only one person. During an interview with DOC #101, they confirmed that the expectation of the home was for staff to be kept aware of the contents of the resident's plan of care and should check the written plan of care after being reassigned. [s. 6. (8)]

7. The licensee shall ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A complaint was submitted to the MOHLTC for resident #036 alleging inappropriate force

during care,that resulted in the resident sustaining an injury.

A review of the resident's most current care plan indicated for three staff to complete all aspects of the toileting task in bed.

During interviews with PSW #126 and PSW #141, they confirmed that they have been transferring the resident to bed and providing toileting care in bed with two staff.

During interviews with DOC #101, CNM #120 and RN #119, they confirmed that the resident's care plan should have been reviewed and revised when the resident's care needs changed and the resident no longer required three staff for toileting. [s. 6. (10) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, that the care set out in the plan of care is provided to the resident as specified in the plan, and that the staff who provide direct care to a resident were kept aware of the contents of the resident's plan of care, the resident was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 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 was fully respected and promoted.

The home submitted a CIS report related to improper care of resident #027. Review of a complaint received by the MOHLTC indicated that the resident was receiving improper care and was being neglected in regards to their toileting needs.

Documents sent to the MOHLTC with the above complaint were reviewed. There was a copy of the complaint letter sent to the home that indicated on an identified date the SDM noted that the resident needed changing before lunch but their primary care giver, PSW #133, was nowhere to be found. While RN #130 and PSW #102 were toileting resident #027, PSW #133 was rolling a cart past the shower room and when asked to help by RN #130, stated it is almost lunch time and I am going to have a proper lunch, I am not toileting them now. According to the SDM's letter, as PSW #133 passed by again, they muttered that residents need to learn to wait.

During an interview with resident #027's SDM, they stated that they remembered PSW #133 walking past the shower room on an identified date, where the resident was being toileted. According to the SDM, PSW #133 stated it was ten minutes before their lunch and they were not going to change the resident now and they will just have to wait.

During an interview with RN #130 they confirmed that PSW #133 refused to help toilet resident #027 on an identified date and said they were going on break. According to the RN, the SDM heard this and became very upset and the RN reported the incident to the nurse manager and DOC because this was "unacceptable." The RN also acknowledged that the resident would have overheard this interaction as well, as they were within proximity. During an interview with PSW #102, they confirmed that PSW #133 stated

would not help with toileting and were going on break.

An interview with PSW #133 was not possible as they were on an extended leave of absence.

During an interview with Administrator #114 they acknowledged that PSW #133 stating they would not provide care to the resident because they were going on break, did not fully respect and promote resident #027's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity. [s. 3. (1) 1.]

WN #3: 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):
4. An injury in respect of which a person 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 no later than one business day after the occurrence of the incident that causes injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The home submitted a CIS report to the MOHLTC, according to this report, resident #026 had pain to an identified body area, and was sent to the hospital the following day and diagnosed with an injury.

A progress note identified that the hospital contacted the home on an identified date stating that the resident had an injury and that discharge was possible for the same day.

During an interview with DOC #101, they acknowledged that the above CIS report was submitted later than one business day after the occurrence of the above mentioned incident involving resident #026. [s. 107. (3) 4.]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.