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

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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
Oct 20, 2021	2021_769646_0016	012766-20, 012981-20, 018305-20, 023705-20, 002662-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

IVY LAM (646), NOREEN FREDERICK (704758)

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): September 16, 17, 20 - 24, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #023705-20 (CIS #M596-000021-20) related to an allegation of staff to resident abuse;
Logs #012766-20 (CIS #M596-000016-20), #012981-20 (CIS #M596-000017-20), and #002662-21 (CIS #M596-000003-21) related to falls with injury; and
Log #018305-20 (CIS #M596-000019-20) related to fracture of unknown cause.

The mandatory Infection Prevention and Control (IPAC) and the cooling requirement inspections were also completed.

NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (1) (c) was identified in this inspection and has been issued in a concurrent inspection, #2021_769646_0017, dated October 20, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Medical Director, Physician, Supervisor of Administrative Services, Director of Care (DOC), Registered Nurses (RNs), Registered Nurses In Charge (RNIC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI)-Lead, Registered Dietitian (RD), Food Service Manger (FSM), Acting Supervisor of Building Services, Infection Prevention and Control (IPAC) Lead, RPN - Falls Team, Behavioural Supports Ontario (BSO) Lead, Physiotherapist (PT), Screeners, Substitute Decision-Makers, and Residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted reviews of residents' record reviews, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
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)**
- **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. (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 care set out in a resident's plan of care related to falls prevention was provided.

The resident's care plan identified that the resident required two falls prevention interventions, and staff assistance with toilet use.

The resident attempted to toilet themselves without assistance which resulted in a fall with injury. At the time of the fall neither of the above mentioned fall prevention interventions were provided to the resident.

[Sources: Resident's progress notes, incident report, care plan and interviews with RNs (Registered Nurse) and the Director of Care (DOC).] [s. 6. (7)]

2. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when a resident's intervention to prevent injury from falls was ineffective.

The resident's Point of Care (POC) documentation indicated that resident refused to use a piece of injury prevention equipment. There were no strategies considered or implemented to manage the resident's refusal to wear the piece of injury prevention equipment.

The home did not reassess or consider different approaches when the resident's plan of care was ineffective. As a result, resident was at risk of falls and injury.

[Sources: Resident's progress notes, incident report, care plan, Point of Care (POC) documentation, and interviews with an RN, DOC and other staff.] [s. 6. (11) (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 if the plan of care is being revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident 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 of resident's fall which caused an injury to the resident for which the resident was taken to a hospital.

Specifically, home did not comply with their policy "Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements", which required the home to report to the Director in one business day if an injury in respect of which the resident was taken to hospital.

The resident had an unwitnessed fall for which they were taken to the hospital and rendered them with an injury, and change in ambulatory status. A report to the Director was not made until seven days later, which did not meet legislative timelines for reporting.

[Sources: Ministry of Health and Long-Term Care Mandatory and Critical Incident Reporting Requirements Policy, Interview with DOC, and Critical Incident Report.] [s. 107. (3)]

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, when an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, the Director is informed no later than one business day after the occurrence of the incident, followed by the required report, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature required to be measured was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

As of May 15, 2021, the licensee was required to measure the temperature and document temperature readings of at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and every designated cooling areas three times daily during the above mentioned periods.

The home's temperature logs showed there were no temperature readings, for any of the above home areas, documented on four day shifts, one evening shift, and two night shifts in the month of August.

The Acting Supervisor of Building Services indicated the home used a computerized monitoring system, and the staff responsible for documenting the temperatures may not have saved the records properly. Some staff also completed the records on paper. No electronic or paper records of temperature readings were found for the identified shifts above.

[Sources: Review of the home's Hot Weather Alert Temperature Log - Day/Evening/Night shift for August and September 2021, Home's Hot Weather Alert Response – Section 05 – Resident Planning Process; Observations; and Interviews with the Acting Supervisor of Building Services and other staff.] [s. 21. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program related to hand hygiene.

Specifically, staff did not comply with the home's hand hygiene policy, which was part of the infection prevention and control program.

The home's policy required that, all staff perform hand hygiene according to the four moments for hand hygiene.

A PSW failed to perform hand hygiene when entering a resident's room to provide care. The PSW failed to perform hand hygiene when entering and exiting a resident's room while serving a snack. As a result, there was a risk of spreading healthcare associated infections.

[Sources: Hand Hygiene policy, Interviews with Infection Prevention and Control (IPAC) lead, and DOC.] [s. 229. (4)]

Issued on this 28th day of October, 2021

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

Original report signed by the inspector.