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_0017	002194-21	Complaint

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)

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

The following intake was completed in this complaint inspection:
Log #002194-21 related to falls prevention and assessment, personal support services, nutrition and hydration, and safe and secure home.

NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6. (1) (c) was identified in a concurrent inspection #2021_769646_0016 (Log #002662-21, CIS #M596-000003-21) and issued in this report.

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, Complainants, and Residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

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

- **1 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. (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).

Findings/Faits saillants :

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

The resident, who had visual impairment and used an assistive mobility device (AMD) for locomotion, had an unwitnessed fall in their bedroom.

Discussions with the resident's Substitute Decision-Makers (SDMs) were held after the fall to relay the home's concerns regarding concerns with the placement of a piece of furniture. Documentation showed the Physiotherapist (PT) and nursing care team had discussed the use and placement of the furniture for the resident.

The care plan between the time of the resident's fall until the time of inspection, did not show any direction or intervention regarding the proper placement of the resident's piece of furniture.

The PSW and registered staff indicated the resident slept in a specific way and the piece of furniture was requested by the family to minimize the resident's risk of falling.

Over the course of the inspection, the inspector observed the resident's piece of furniture placed in various positions in the resident's room by different staff members while the resident was in bed. A Registered Practical Nurse (RPN) indicated they would position the resident's furniture one way, and a Personal Support Worker (PSW) indicated they would position the furniture another way.

Another RPN, who assisted with the home's falls prevention program, indicated the family's preference was the furniture in a third way which allowed the piece of furniture to be more stable.

The PT indicated discussions were held with the SDMs and registered staff regarding the risks posed by the placement and use of the piece of furniture. The PT indicated that they had not put the described intervention and its proper positioning in the care plan.

The Director of Care (DOC) indicated that there were no clear directions to the staff regarding the placement of the resident's piece of furniture.

There was a risk of the resident falling when the plan of care set out for the resident did not provide clear directions regarding the piece of furniture to staff and others who provided direct care to the resident.

[Sources: Resident's risk management notes, care plan prior to and after the resident's fall, physiotherapist (PT) assessments, progress notes; observations of the resident and the resident's room; interviews with Personal Support Worker (PSW), Registered Practical Nurses (RPNs), Registered Nurse - Behavioural Supports Ontario (RN-BSO) lead, PT, and Director of Care (DOC), and the complainant.] [s. 6. (1) (c)]

2. The licensee has failed to ensure that a resident's plan of care provided clear directions to staff related to toilet use.

Long-Term Care Homes Act, 2007, s. 6 (1) (c) requires the licensee to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The resident's care plan identified that the resident required staff assistance an identified care; however, the same care plan identified that resident was able to go to do the care independently with an assistive mobility device (AMD).

As a result of the lack of clear direction in the resident's plan of care, the resident did not receive the identified assistance for their care on the day they sustained an unwitnessed fall with an injury.

[Sources: Resident's progress notes and care plan, and interview with Director of Care

(DOC).] [s. 6. (1) (c)]

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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.