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

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

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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 2, 2022	2022_937759_0003	015512-21	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

APRIL CHAN (704759)

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): January 19, 20, 21, 24 and 25, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:

Log# 015512-21, CIS #M596-000006-21, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) lead, Manager of hospital IPAC hub, Public Health Investigator, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed the home's IPAC practices, the provision of care, reviewed records including the home’s investigation records, policies and procedures, residents' clinical health records, and staff schedules.

Inspector Daria Trzos (#561) was present as an assessor for this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On January 19, 2022, a staff member was observed by Inspector #704759 wearing an N95 respirator over a surgical mask while administering medication for a resident under droplet and contact precautions.

Review of the home's procedure, titled N95 Respirator: Wearing it Right, showed that N95 respirators are placed directly over the nose and mouth, then the seal is checked. The IPAC lead stated that staff members should not wear a surgical mask underneath an N95 respirator for the reason that it may disrupt the seal of the N95 respirator.

Sources: observations, the home's procedure N95 Respirator: Wearing it Right, interviews with IPAC lead and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee has failed to ensure that actions taken with respect to a resident’s use of an intervention under the fall prevention program, including reassessment, intervention and the resident’s response to the intervention was documented.

A CIS report was received by the Ministry of Long-Term Care for an fall incident that resulted in an injury to the resident for which the resident was taken to hospital.

The resident was at risk for falls, had cognitive and physical impairments, and attempted self-transfers without assistance.

On a specific date, the resident was found lying on the floor and complained of pain. The resident’s physician was notified and an x-ray was ordered. A few days later, the resident was found again on the floor, and was later transferred to hospital. Previous to these falls, the resident was assessed and the use of a specific intervention was documented by the home’s physiotherapist on three specific dates, and by the occupational therapist on three other specific dates.

Per the home’s fall prevention program policy, the RN or RPN was to document re-assessment results and to initiate further referrals based on the re-assessment data. The physiotherapist and an RPN staff member stated that the specific intervention were offered again for the resident prior to their fall incidents. The RPN and the DOC confirmed that refusal or noncompliance of an intervention should be documented in the progress notes. Review of the resident’s care plan and progress notes from before the fall incidents showed that the reassessment or the resident’s response was missing from the documentation.

Sources: CIS report, review of the resident's clinical assessments and records, review of the home’s Falls Prevention and Management policy and interview with staff members. [s. 30. (2)]

Issued on this 7th day of February, 2022

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

Original report signed by the inspector.