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

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Original Public Report

Report Issue Date: December 14, 2022	
Inspection Number: 2022-1595-0002	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Carefree Lodge, North York	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2022.12.29 09:04:42 -05'00'
Additional Inspector(s) Ivy Lam (646) and Adam Dickey (643) were present during this inspection as assessing mentors.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5-8, 2022

The following intake(s) were inspected:

- Intake: #00002213 - Critical Incident System (CIS): M596-000006-22 - related to falls prevention and management

The following intake(s) were completed in the CIS inspection: Intake #00002590 (CIS M596-000004-22) and Intake #00004141 (CIS M596-000011-22) - related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the IPAC Lead failed to ensure that the hand hygiene program included access to 70-90% Alcohol-Based Hand Rub (ABHR) as was required by Additional Requirement 10.1 under the IPAC Standard. The IPAC lead failed to remove expired ABHR that was in use in the home.

Rationale and Summary
On a specified date, a bottle of expired ABHR was located by a resident's room.

After the home was notified of the observation, the IPAC Practitioner and the Administrator stated on the next day, that all expired ABHR had been removed from being in use. The IPAC Practitioner indicated that the expired ABHR would not be as effective to kill all the microorganisms, hence there was risk of infection transmission.

There was low risk to residents as ABHR from wall mounted dispensers were more frequently used and they were not expired.

Sources: Inspector #740849's observations, Interview with IPAC Practitioner.

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Date Remedy Implemented: December 6, 2022

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the additional requirements under the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

Specifically, Additional Requirement 9.1 (f) under the IPAC Standard states that the licensee shall ensure that Additional Precautions are followed in the IPAC program, including appropriate PPE selection application, removal, and disposal.

Rationale and Summary
(i) A Personal Support Worker (PSW) donned PPE outside of a resident's room that required droplet and contact precautions. The donning process was as follows: hand hygiene, doffed surgical mask, donned N95 respirator, donned gown, gloves and face shield.

A donning PPE signage was posted on the resident's room indicating to don the gown before the mask. This was consistent with the home's PPE policy.

The PSW and the IPAC Practitioner indicated that hand hygiene should have been performed after doffing the surgical mask. They also stated that the gown should have been donned before doffing the surgical mask.

There was risk of contamination and infection transmission when the appropriate donning process was not followed.

Sources: Inspector #740849's observations, Interview with a PSW and IPAC Practitioner, the home's PPE policy (IC-0604-00, published 01/05/2015), donning signage on a resident's door.

(ii) A resident required a procedure that was done at a specified time daily. A signage on the resident's door indicated that full PPE was required between a specified time. Full PPE consisted of N95 respirator, face protection, gown, and gloves.

There was a second precaution signage posted on the resident's door.

A Registered Practical Nurse (RPN) indicated that the first signage was for another shift to follow therefore only the second precaution signage would be followed during their shift. They further indicated that only surgical mask was required when delivering medication and meal trays because there would be no contact with the resident. A PSW practiced the same precautions as the RPN as they were following instructions provided by the nurse in charge.

The IPAC Practitioner clarified that full PPE was required when entering the resident's room between the specified time on the first precaution signage. For the remaining hours of the day, the second precaution signage must be followed whenever a person enters the resident's room, even if it was to deliver a meal tray or medication.

There was risk of contamination and infection transmission when the appropriate PPE use was not followed.

Sources: two precaution signages on a resident's door, Interviews with a PSW, RPN, and IPAC Practitioner.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed and the plan of care was revised when the care set out in the plan was not effective.

Rationale and Summary
A resident was identified to be at risk for falls. The resident was cognitively impaired and would frequently attempt to get out of bed without calling for help.

The resident had four unwitnessed falls within three months, in their bedroom. The resident was found at bedside in three out of the four falls.

The resident's plan of care was not updated with strategies to minimize falls and fall-related injuries after the three falls in the first two identified months. No documentation was found relating to

interdisciplinary discussions on strategies to minimize falls and fall-related injuries for the resident during the same timeframe. The weekly interdisciplinary falls huddle record indicated that the resident was not discussed as an interdisciplinary team after the identified falls.

After the fourth fall, two interventions were recommended by the Physiotherapist (PT) and a referral was sent to the Occupational Therapist (OT).

The PT indicated that a reason for recommending one of the interventions was when a resident had reoccurring falls at bedside. They also stated that a reason for recommending the second intervention was if a resident had frequent attempts to get out of bed.

The PT and the Falls Lead for Nursing stated that the PT and OT could recommend falls prevention equipment, but nursing staff could also provide falls prevention equipment based on their assessment and send a referral to the rehab team to re-evaluate.

An RPN and the PT stated that both recommendations should have been implemented earlier after the resident sustained multiple falls. The PT and the Falls Lead for Nursing indicated that an OT referral should have been sent earlier after the resident sustained multiple falls. The home's Falls Prevention and Management policy (RC-0518-21, published September 15, 2022) states that if the PT feels that further expertise of the OT is required, the PT will send a referral to the OT.

The RPN stated that there were no known interdisciplinary discussions to prevent further falls after the first three mentioned falls. The Falls Lead for Nursing also stated that a weekly interdisciplinary falls huddle should have been done for the resident after multiple falls. The Nurse Manager indicated that the interventions during the first three falls were not effective to minimize fall related injuries. The home's Falls Prevention and Management policy (RC-0518-21, published September 15, 2022) states that the care team should review fall preventative strategies and modify plan of care when the evaluation of the interventions demonstrates that the interventions were ineffective.

There was risk to the resident as injury was sustained after the third mentioned fall.

Sources: The resident's progress notes and care plan, the weekly interdisciplinary falls huddle record, Interviews with the PT, Falls Lead for Nursing, RPN, and Nurse Manager.

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