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: October 4, 2024

Inspection Number: 2024-1595-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Carefree Lodge, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 2024

The following intake(s) were inspected:

- Intake: #00118280 - [Critical Incident (CI): M596-000010-24] - Disease outbreak
- Intake: #00119156 - [CI: M596-000011-24] and Intake: #00123066 - [CI: M596-000016-24] - Abuse and Neglect
- Intake: #00120403 - Follow-up - Infection Prevention and Control (IPAC)
- Intake: #00122573 - [CI: M596-000015-24] - Fall with injury
- Intake: #00124093 - [CI: M596-000017-24] - Improper/Incompetent care
- Intake: #00125420 - Complain- Improper/Incompetent care, fall with injury, and equipment

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1595-0002 related to O. Reg. 246/22, s. 102 (2) (b) was inspected.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
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 inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was fully respected and promoted by a Personal Support Worker.

Rationale and Summary
A resident reported that a PSW mistreated them resulting in the resident experiencing a negative emotional response. A Registered Nurse (RN) witnessed an interaction between the resident and the PSW where the PSW mistreated the resident. The Executive Director (ED) acknowledged that the PSW did not treat the resident with courtesy and respect.

Failure to ensure that the PSW treated the resident with respect and dignity resulted in negative emotional impact to the resident.

Sources: the Long Term Care Home's (LTCH) investigation notes, CIS #M596-000011-24, Interviews with an RN and the ED.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
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;
The licensee has failed to ensure that a PSW collaborated with the registered staff in the assessment of a resident when they refused their fall prevention intervention which was part of their fall prevention and management.

Rationale and Summary
A resident was at high risk for falls. Their care plan stated use of fall prevention intervention if the resident is in compliance with it. A PSW stated that the resident

refused their intervention at all time and they did not report this refusal to anyone. Two Registered Practical Nurses (RPNs) stated that the PSW never reported the refusal of the intervention to them therefore no actions were taken.

The Director of Care (DOC) stated that the intervention was an ineffective intervention since the resident refused it and acknowledged that collaboration did not occur when the PSW did not report the refusal and therefore a reassessment was not completed.

Staff's failure to collaborate with each other put the resident at risk of not receiving effective interventions to reduce risk of injury from falls.

Sources: resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The resident's care plan indicated that they required two-person extensive assistance for specific ADLs. A PSW stated that they transferred the resident alone twice. The DOC stated that the PSW should not have transferred the resident by

themselves if the care plan stated that they required two person transfer.

Failure to ensure that the resident was provided with care as set out in their care plan, placed the resident at risk for a potential injury.

Sources: resident's care plan, and interviews with a PSW and the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident had a fall and reported pain. As a result of the fall, the resident was transferred to the hospital where they were diagnosed with severe injuries.

The LTCH's investigation notes revealed that three staff members transferred the resident from one location to another manually. The PSW, and two RPNs all confirmed the same. The Physio Therapist (PT) stated that a mechanical lift was the safest way to transfer the resident. The DOC stated that staff should have used a mechanical lift as a safe transferring technique.

As a result of improper transferring techniques, the resident was placed at risk for further injury.

Sources: resident's clinical records, LTCH's investigation notes, and interviews with a PSW, RPNs, PT and the DOC .