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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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
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Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2020	2020_817652_0005	008659-20	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

St. George Care Community
225 St. George Street TORONTO ON M5R 2M2

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

NATALIE MOLIN (652)

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): This inspection was completed off-site on May 14, June 12, 17, 18 and July 13, 2020

The following critical incident system (CIS) inspection was conducted related to Unexpected Death of a Resident

During the course of the inspection, the inspector(s) spoke with the executive director (ED),director of care (DOC), registered nursing staff, personal support workers (PSWs), registered dietitian (RD).

During the course of the inspection, the inspector conducted records review and staff interviews.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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

1 WN(s)
0 VPC(s)
1 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).

Findings/Faits saillants :

The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report were submitted to the Ministry of Long-Term Care (MLTC) related to the choking incident of resident #001.

A review of the CIS report and the incident form indicated, during an identified meal time, resident #001 was sitting at the table; physically distanced from other residents, when resident suddenly stood up and told PSW #100 who was serving, " I'm choking". Staff began abdominal thrusts, and noted, a small amount of food coming out of resident #001's mouth. 911 and code blue were called. Full cardiopulmonary resuscitation (CPR) was started. The Paramedics arrived and removed a large piece of food from resident #001's throat and they were intubated, transferred to hospital where they died that same day.

Record review of resident #001's interdisciplinary care conferences indicated, that they required supervision for meals and was at high risk for choking.

Record review of the Speech Language Pathologist's (SLP) assessment on an identified date, indicated the chief complaint was that resident #001 had experienced, cough/difficulties with an identified food item. This report also mentioned that resident #001 was able to feed themselves, however needed supervision and prompting to eat slowly.

A dietary referral form confirmed the assessments and recommendations by the SLP. This form also indicated, the Registered Dietitian (RD) had discussions with the charge nurse (CN) to move resident #001 from one identified table to another, where there was always a staff providing supervision/monitoring of another resident, and that resident #001 remained at high nutritional risk.

Record review of resident #001's bedside Kardex indicated they were at high risk for choking.

Record review of resident #001's written plan of care at the time of the incident indicated they were at high risk for choking. This plan of care directed staff to supervise resident #001, set-up their meals, provide prompting to chew slowly and swallow before taking another bite.

In an interview PSW #100 confirmed resident #001 tended to eat a little fast and on the day of the incident, they were fixing trays for other residents, their back was turned to

resident #001 when they called out that they were choking.

In an interview RPN #102 confirmed they were coming out of another room when they responded to resident #001’s choking incident, and were not providing supervision for resident #001, the PSW and dietary aide were there. RPN #102 also said, the staff must supervise resident #001 during meals, but resident #001 did not want to stay in their room and was sitting at their table alone in the dining room.

The Executive Director of Care and Director of Care acknowledged that resident #001's was not monitored during meals as per their plan of care.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 5th day of August, 2020

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NATALIE MOLIN (652)

Inspection No. / No de l'inspection : 2020_817652_0005

Log No. / No de registre : 008659-20

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jul 24, 2020

Licensee / Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD : St. George Care Community
225 St. George Street, TORONTO, ON, M5R-2M2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Nancy de Vera

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that residents who have been identified as high risk for choking an identified as requiring supervision during meals, are closely monitored and supervised

The plan must include, but is not limited, to the following:

a. Develop and implement a process to ensure, that all residents within the home who has been identified as high risk for choking receive monitoring and supervision during meals.

b. Implement an auditing process to ensure that all residents at high risk for choking are monitored and supervised.

c. Maintain a written record of audits conducted. The written record must include the date,
the resident's name, staff member's name, the name of the person completing the audit
and the action taken from the outcome of the audit.

Please submit the written plan to inspector Natalie Molin by email to torontosao.moh@ontario.ca by August 4, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report were submitted to the Ministry of Long-Term Care (MLTC) related to the choking incident of resident#001.

A review of the CIS report and the incident form indicated, during an identified meal time, resident #001 was sitting at the table; physically distanced from other residents, when resident suddenly stood up and told PSW #100 who was serving, " I'm choking". Staff began abdominal thrusts, and noted, a small amount of food coming out of resident #001's mouth. 911 and code blue were called. Full cardiopulmonary resuscitation (CPR) was started. The Paramedics arrived and removed a large piece of food from resident #001's throat and they were intubated, transferred to hospital where they died that same day.

Record review of resident #001's interdisciplinary care conferences indicated, that they required supervision for meals and was at high risk for choking.

Record review of the Speech Language Pathologist's (SLP) assessment on an identified date, indicated the chief complaint was that resident #001 had experienced, cough/difficulties with an identified food item. This report also mentioned that resident #001 was able to feed themselves, however needed supervision and prompting to eat slowly.

A dietary referral form confirmed the assessments and recommendations by the SLP. This form also indicated, the Registered Dietitian (RD) had discussions with the charge nurse (CN) to move resident #001 from one identified table to another, where there was always a staff providing supervision/monitoring of another resident, and that resident #001 remained at high nutritional risk.

Record review of resident #001's bedside Kardex indicated they were at high risk for choking.

Record review of resident #001's written plan of care at the time of the incident indicated they were at high risk for choking. This plan of care directed staff to supervise resident #001, set-up their meals, provide prompting to chew slowly and swallow before taking another bite.

In an interview PSW #100 confirmed resident #001 tended to eat a little fast and

on the day of the incident, they were fixing trays for other residents, their back was turned to resident #001 when they called out that they were choking.

In an interview RPN #102 confirmed they were coming out of another room when they responded to resident #001’s choking incident, and were not providing supervision for resident #001, the PSW and dietary aide were there. RPN #102 also said, the staff must supervise resident #001 during meals, but resident #001 did not want to stay in their room and was sitting at their table alone in the dining room.

The Executive Director of Care and Director of Care acknowledged that resident #001's was not monitored during meals as per their plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it was isolated. The home had a level 3 compliance history of previous non-compliance same subsection of the Act that included:
-Voluntary plan of correction (VPC) issued May 24, 2019, (2019_642698_0007)
-Voluntary plan of correction (VPC) issued November 6, 2019, (2019_630589_0023)
- Voluntary plan of correction (VPC) issued November 27, 2018, (2018_751649_0019)

(652)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of July, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Natalie Molin

Service Area Office / Bureau régional de services : Toronto Service Area Office