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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: September 28, 2023
Inspection Number: 2023-1107-0002
Inspection Type: Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: St. George Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Chinonye Nwankpa (000715)	Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2023.10.12 16:41:42 -04'00'

Additional Inspector(s)
Nital Sheth (500)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5-8, 2023. The following intake(s) were inspected in the Critical Incident System Inspection:

- Intake: #00020454 - Critical Incident (CI) #2594-000004-23 – Related to falls prevention and management
- Intake: #00021146 - CI #2594-000005-23 – Related to transferring and positioning
- Intake: #00092803 - CI #2594-000018-23 – Injury of unknown cause

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (3)

The licensee has failed to ensure that the plan of care of a resident included all aspects of their care.

Rationale and Summary
A resident exhibited behaviours when they were being transferred with a device from their bed. Two Personal Support Workers (PSW) reported the resident exhibited a behaviour during the transfer and sustained an injury. The PSW shared that the resident had a history of displaying specific behaviours during transfers, however their care plan did not indicate these behaviours or interventions to manage the behaviours.

The Associate Director of Care (ADOC) and the PSW both noted when the resident started exhibiting the behaviour, the transfer should have been stopped and the resident reapproached at a later time. The ADOC acknowledged that the resident's behaviour and applicable interventions were not documented in their care plan.

There was risk of injury to the resident when their care plan did not include behaviour management interventions.

Sources: Resident's clinical records; interviews with PSWs and ADOC. [000715]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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
A resident's care plan stated to get them out of bed on specific days of the week. Two PSWs transferred the resident out of bed on a day that was not specified in their care plan.

The resident exhibited behaviours during a transfer from their bed and sustained an injury. A PSW

expressed this change in behaviour signified that the resident did not want to be transferred out of bed. The PSW acknowledged they initiated the transfer on a day not specified in the resident's care plan.

The ADOC acknowledged the resident's care plan was not followed, and their preferences were not respected.

Failing to follow the specified days for transferring the resident increased their risk of behaviours which may have led to their injury.

Sources: Resident's clinical records; interviews with PSWs and ADOC. [000715]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Perform weekly audits of mechanical lift transfers completed by identified PSWs for a period of four weeks following the service of this order.
2. Maintain a written record of the audits, including the date, staff audited, resident audited, person conducting the audit, and actions taken in response to the audit findings.
3. Re-educate identified PSWs on the home's Zero Lift and Transfer policy.
4. Maintain a record of the education, including the content provided, date, signatures of staff who attended the education and the person who provided the education.

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

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to an injury of a resident that resulted in a hospital transfer and a significant change in health status.

The home's Zero Lift and Transfer policy outlined that staff were to receive initial and annual mandatory training on lift devices, Zero Lift policy, and safe resident lifting techniques. The policy further stated that two qualified staff must be present when operating the mechanical lift.

The resident sustained injuries during a transfer with a device from their bed to wheelchair. The PSW advised that one of the persons who performed the transfer was a PSW student and should not have performed the resident's transfer with them.

The home's investigation notes revealed that the PSWs performed an unsafe transfer.

ADOC confirmed that the PSW student was not qualified to perform a mechanical lift transfer, as the home's protocol excluded students from participating in the lift and transfers. Furthermore, both ADOCs acknowledged that the PSW student had not received the home's training on lifts and transfers.

The resident sustained a significant injury when staff performed an unsafe transfer with unqualified personnel.

Sources: CI report; resident’s hospital records; the home's Zero Lift and Transfer policy; interviews with PSWs and ADOCs. [000715]

This order must be complied with by October 27, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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