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: November 29, 2023

Inspection Number: 2023-1107-0003

Inspection Type:
Critical Incident
Follow up

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**
Fiona Wong (740849)	Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.12.01 09:33:26 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 10, 14-16, 20, 2023.

The following intake(s) were inspected:

- Intake: #00098138 was related to falls prevention and management.
- Intake: #00098203 was a follow up intake related to transferring and positioning.
- Intake: #00098487 was related to administration of drugs.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1107-0002 related to O. Reg. 246/22, s. 40 inspected by Fiona Wong (740849)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

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 (9) 1.
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision a resident's care set out in their plan of care was documented.

Rationale and Summary

On a specified day, a resident was prescribed a medication by their physician. The physician's order was incorrectly processed in the resident's electronic Medication Administration Record (eMAR), therefore registered staff were unable to appropriately document the administration of this medication.

Registered Practical Nurse (RPN) #112 stated that on two consecutive days, they administered the prescribed medication to the resident as per physician's order, however the administration was not documented in the resident's eMAR nor anywhere else in the Point Click Care (PCC) system.

RPN #113 stated that on a specified day, they administered the prescribed medication to the resident as per physician's order, however the administration was not documented in the resident's eMAR, but it was documented in the progress notes section of the PCC system.

An Associate Director of Care (ADOC) stated that medication administration should be documented in resident's eMAR. They acknowledged that the documentation of this medication administration was not completed as set out in the resident's plan of care.

Failure to document the administration of a medication increased the risk of not knowing the effectiveness of the medication and the frequency of the medication administration.

Sources: the resident's clinical records, interviews with an RN, two RPNs, an ADOC and other staff.

[740849]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The licensee has failed to ensure that the Director was informed, no later than one business day after the occurrence, of a medication incident which resulted in a resident being taken to the hospital.

Rationale and Summary
A CI was submitted to the Director of a medication incident for a resident. On a specified day, the resident was prescribed a medication that was not administered to them as prescribed by the physician. The resident was sent to the hospital a number of days later, when their condition worsened.

An ADOC acknowledged the Director was not notified of the medication incident on time when the CI report was submitted 21 days late.

Sources: Interview with an ADOC, CI Report, the resident's clinical records.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
On a specified day, a resident was prescribed a medication by their physician. An RN stated that they had mistakenly processed and confirmed the order in the resident's eMAR to administer the medication at an incorrect frequency.

Two RPNs verified by co-signing the order, but both did not identify the error within the order. As a result of the error, the resident's eMAR did not prompt registered staff to administer the medication as specified by the physician.

The RN acknowledged that the medication was not administered to the resident as prescribed by the doctor.

Failure to administer the medication in accordance with the directions for use specified by the prescriber increased the risk of delaying the improvement or

worsening the resident's health condition.

Sources: The resident's clinical records, interviews with an RN, two RPNs, and other staff.

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