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: 2023-1595-0005	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Carefree Lodge, North York	
Lead Inspector Michael Chan (000708)	**Inspector Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2023.10.12 09:40:36 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18-20, 22, 2023.

The following intake was inspected in this Complaint Inspection:

Intake: #00096466 - Complaint related to care concerns and change in status of a resident

The following intake was inspected in this Critical Incident (CI) Inspection:

Intake: #00094619 [CI: M596-000014-23] - Allegation of neglect to a resident

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Integration of Assessments, Care

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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

(a) Provide education to all registered staff regarding an incident with a resident, the factors that contributed to a resident's deterioration in condition and what could be done to mitigate future incidents. A record must be kept of the education provided, who received the education, date of completion, and who provided the education.

(b) Conduct weekly audits on a specified floor for a three-week period to review any telephone orders and ensure that any telephone orders requiring any follow-up are documented on the Physician Communication Log.

(c) Maintain a written record of audits completed, to include, but not limited to, residents audited, staff audited, results of audits and any actions taken in response to audit findings.

Grounds
The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary
On a specified date, staff documented that a resident's condition changed. A staff assessed the resident and communicated via telephone with the attending physician to inform them of the resident's condition. Staff would have been expected by the home to document their findings on the Physician Communication Log despite the previous telephone communication with the attending physician so that the physician would be aware and assess the resident during their rounds. The home confirmed that there was no documentation made on the Physician Communication Log to communicate the resident's condition during a specified week. Additionally, a staff acknowledged that they had not communicated their assessment of the resident to the registered staff. The resident's condition deteriorated, and they were transferred to the hospital and had further changes to their condition.

The physician was unaware of the resident's deteriorating condition until the date the resident was transferred to the hospital. Furthermore, the physician indicated that their expectation is for the registered nursing staff to document pertinent information related to the resident's condition on the Physician Communication Log to allow them to follow-up with the resident during their rounds. The physician stated that if they had seen the resident during their rounds, the resident may have been provided further medical intervention which may have resulted in a better outcome for the resident. The physician and staff verified that the resident's deteriorating condition should have been followed-up by the physician during their rounds. Moreover, a staff confirmed that if the physician had been informed of the resident's deteriorating condition that the resident may not had their health further compromised.

The home confirmed that a staff failed to document in the Physician Communication Log to inform the physician to follow-up on the resident deteriorating health condition. The home identified gaps in the communication and escalation processes by staff. Staff and the physician confirmed the home's processes in communicating and escalating any concerns about a resident's condition were not followed.

Staff's failure to communicate and escalate the resident's condition in the Physician Communication Log led to inconsistency in the assessment of the resident and therefore led to the possible decline of the resident's condition.

Sources: A resident's clinical record, home's investigation notes, interviews with management and other staff.

[000708]

This order must be complied with by November 9, 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.