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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: April 4, 2024	
Inspection Number: 2024-1595-0001	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Carefree Lodge, North York	
Lead Inspector Yannis Wong (000707)	Inspector Digital Signature Yannis Wong Digitally signed by Yannis Wong Date: 2024.04.05 11:07:44 -04'00'
Additional Inspector(s) Inspector Betty-Jo Horan (000824) was present during this inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 18-22, 25-27, 2024

The following intakes were inspected:

- Intake: #00108396 - complaint related to abuse and continence care
- Intake: #00108502 - [Critical Incident (CI): #M596-000003-24] - related to a disease outbreak
- Intake: #00108607 - [CI: #M596-000004-24] - related to fall and significant change with hospital transfer

The following intakes were completed:

- Intake: #00103455 [CI: #M596-000021-23] - related to a disease outbreak
- Intake: #00106167 [CI: #M596-000001-24] - related to a disease outbreak
- Intake: #00107416 [CI: #M596-000002-24] - related to a fall resulting in injury
- Intake: #00109312 [CI: #M596-000005-24] - related to a fall resulting in injury

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance.

Rationale and Summary
An enteric outbreak was declared by Toronto Public Health (TPH).

A critical incident (CI) report for this disease outbreak was not submitted to the Director until three days later. The home also called the After Hours line three days later. The Infection Prevention and Control (IPAC) Practitioner and Director of Nursing (DON) confirmed the outbreak should have been reported to the Director immediately.

Failure to report the outbreak immediately could delay follow up actions by the Director.

Sources: CI #M596-000003-24; home's emails with TPH; interview with IPAC Practitioner and DON. [000707]

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 (5) 2. i.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,

The licensee failed to inform the Director of the name of a resident involved in the Critical Incident report.

Rationale and Summary
The home submitted a CI report to the Director about an incident and did not include the name of the resident involved. The Director requested an amendment to the CI to include the full name of the resident. The home did not complete the amendment until after the inspector brought it to the home's attention during an on-site inspection.

The DON acknowledged the resident was identified by their initials in the CI and their full name should have been included but was not included in the report.

Failure to include the resident's name in the CI report as required, may impact the Director's ability to follow up on the incident.

Sources: CI #M596-000004-24; interview with DOC. [000707]