Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_324535_0019	025808-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO 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

VERON ASH (535)

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): November 15, 16, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Nurse Supervisor (NS), Behavior Support Lead, registered nurses (RN), registered practical nurse (RPN), personal support workers (PSW), the resident and substitute decision maker (SDM).

During the course of the inspection, the inspector conducted observation of staff to resident interactions, provision of care, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **0 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	Legendé 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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

The Ministry of Health (MOH) received a critical incident related to an alleged abuse of a resident by a staff member in the home.

On an identified date, registered staff #105 received a call from resident #001's family member stating that the resident had called and complained of being abused by personal support worker (PSW) #103, while the PSW provided care during the previous shift. During an interview, the family member confirmed that they received the call from the resident stating the same.

During an interview, the primary PSW #102 provided care for the resident the immediate shift after the alleged incident occurred; and stated that the resident was his/her usual self; and there was no signs of trauma to the resident observed when personal care was provided to the resident during the shift. The PSW also informed the inspector that he/she was not aware that the resident wanted specific PSWs to provide personal care and hygiene. During an interview, registered staff #105 stated that he/she might have heard something about the resident wanting specific PSWs providing personal care in the past, but could not recall the precipitating factor.

During an interview, the nurse supervisor #106 confirmed that he/she was aware that the resident wanted specific PSWs to provide personal care. He/she also recalled that sometime in the past, resident #001 confabulated a story accusing a PSW of being rough. The nurse manager further stated that on the night of the alleged abuse incident, he/she had to place a PSW on the unit because the unit was short staff. In addition, the nurse manager stated that although he/she knew the resident wanted specific PSWs to provide personal care; he/she believed the both PSWs working during the shift would have worked together to provide care for residents so that should something happen there would be another person to verify the story. The nurse supervisor acknowledged that all direct care providers should have been made aware that the resident wanted specific PSWs provide personal care. Record review revealed that after the incident the written plan of care was updated to include this information. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported was immediately investigated.

The Ministry of Health (MOH) received a critical incident (CI) related to an alleged abuse of a resident by a staff member in the home.

According to the CI, on an identified date registered staff #105 received a call from resident #001's family member stating that the resident had complained of being abused by personal support worker (PSW) #103 while providing care. During an interview, registered staff #105 confirmed receiving the call from the family member towards the end of his/her shift; and confirmed documenting the alleged abuse in the progress notes. Registered staff #105 stated that he/she had reported the incident of alleged abuse to the oncoming registered staff and Nurse Supervisor #106 at the end of his/her shift.

During an interview, Nurse Supervisor #106 acknowledged receiving the information related to the alleged abuse during shift report; however he/she stated there was not enough information shared during report or documented in the progress notes by the registered staff to begin the process of investigation. Furthermore, the Nurse Supervisor confirmed that he/she did not contact the registered staff at home to gather more information; did not contact the PSW involved in the alleged incident, nor spoke with the family member who called the home earlier during the shift; and did not speak with the resident involved in the incident during the shift.

During an interview, the home's Assistant Director of Care (ADOC) confirmed that he/she was the manager on-call during that period, however, he/she was not made aware of the incident by the Nurse Supervisor until the next day. At the time of notification the next day, the ADOC directed the Nurse Supervisor to initiate the investigation, and report the incident of alleged abuse to the MOH, and report the incident to the police as appropriate.

During an interview, the home's Director of Care stated the expectation was for the Nurse Supervisor to follow the home's abuse policy and immediately conduct an investigation at the time he/she became aware of the alleged incident of abuse. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person, who had reasonable grounds to suspect that abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Health (MOH) received an after hour's call by the paging system related to an incident which revealed resident #001 was allegedly abuse by a staff member in the home.

On an identified date, registered staff #105 received a call from resident #001's family member stating the resident had complained of being abused by personal support worker (PSW) #103 while providing personal care. During an interview, registered staff #105 confirmed receiving the call from the family member towards the end of his/her shift; and documented the alleged abuse in the progress notes. Registered staff #105 stated that he/she had reported the incident of alleged abuse to the oncoming registered staff and Nurse Supervisor #106 at the end of his/her shift.

During an interview, Nurse Supervisor #106 acknowledged receiving the information related to the alleged abuse during shift report; however he/she had a very busy shift; was doubtful the incident actually occurred; and did not contact the MOH to report the alleged abuse.

During an interview, the home's Director of Care stated the expectation was for the Nurse Supervisor to follow the home's abuse policy and immediately report the alleged incident of abuse to the MOH when he/she became aware of the incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person, who had reasonable grounds to suspect that abuse of a resident had occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken to meet the needs of the resident with responsive behaviors including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

The Ministry of Health (MOH) received a critical incident related to an alleged abuse of a resident by a staff member in the home.

Record review revealed that resident #001 was assessed by the home's Minimum Data Set (MDS) to require cueing and supervision. The MDS assessment also revealed the resident displayed responsive behaviors.

During an interview, the family member stated the resident was experiencing intermittent episodes of behaviors at times, especially after medication changes; and the resident had accused various family members of physical abuse in the past. Record review revealed that the resident's medication was recently decreased by the physician; however, there was no behavior monitoring record initiated by the home with the medication change.

On an identified date, registered staff #105 received a call from resident #001's family member stating the resident had called and complained of being abused by personal support worker (PSW) #103, when the PSW provided care during the previous shift. During an interview, the family member confirmed that they received the call from the resident stating the same. During an interview, resident #001 stated the same information with minimum word changes to the inspector.

During an interview, PSW #103 denied the incident occurred; and stated that he/she was shocked by the accusation because the resident was fully cooperative during the shift. The inspector observed PSW #103's actions and movement in and out of the resident room during the shift, by reviewing a video recorded on the unit. The information observed on the video recording was consistent with the information provided by the PSW during the interview as it relates to the care provided to the resident during his/her shift.

During an interview, the Behavior Support Program Lead #100 stated there was no previous behavioral assessment or documentation related to the resident's responsive behaviors. He/she confirmed the resident was never referred to the internal or external outreach team for behavior assessment; and that there was a discrepancy in the electronic documentation because the resident behaviors were not brought forward to the behavior team prior to this incident.

During an interview, the DOC stated that because of the home's unique population and culture of care, he/she suspected that direct care providers sometimes normalize residents' responsive behaviors instead of identifying and documenting as such, and referring residents to the behavior team for assessment. Furthermore, the DOC stated that going forward; the expectation was that registered staff members refer residents with behaviors to the internal Behavior Support Program Lead and accept support to manage behaviors; with subsequent referrals to external resources as appropriate. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that actions are taken to meet the needs of the resident with responsive behaviors including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Ministry of Health (MOH) received a critical incident related to an alleged abuse of a resident by a staff member in the home.

On an identified date, registered staff #105 received a call from resident #001's family member stating that the resident had complained of being abused by personal support worker (PSW) #103 while providing care. During an interview, registered staff #105 confirmed receiving the call from the family member at the end of his/her shift; and documented the alleged abuse in the progress notes. Registered staff #105 stated that he/she had reported the incident of alleged abuse to the on coming registered staff and Nurse Supervisor #106 at the end of his/her shift.

During an interview, Nurse Supervisor #106 acknowledged receiving the information related to the alleged abuse during shift report; however he/she did not contact the police to report the alleged abuse because he/she was not aware if the registered staff already contacted the police during the previous shift since the information was not shared during shift report.

During an interview, the home's Director of Care stated the expectation was for the Nurse Supervisor to follow the home's abuse policy and report the alleged abuse to the police based on the information collected upon immediate investigation when he/she became aware of the incident.

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.