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
Oct 23, 2018	2018_514566_0010	023099-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

ARIEL JONES (566)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 4, 9, 10, 11, 12, and 19, 2018.

The following Critical Incident System (CIS) inspections were conducted concurrently with this inspection under separate cover, report #2018_751649_0019:
Log #014283-17 / CIS #2594-000045-17 and Log #014840-17 / CIS #2594-000047-17 (related to falls prevention and management);
Log #016910-17 / CIS #2594-000051-17, Log #018641-17 / CIS #2594-000053-17, Log #024596-17 / CIS #2594-000058-17 and Log #027911-18 / CIS #2594-000059-18 (related to duty to protect);
and Log #029721-17 / CIS #2594-000069-17 (related to elopement).

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), assistant Directors of Care (ADOC), evening nurse manager (NM), registered nursing staff (RPN/RN), and personal support workers (PSW).

During the course of the inspection, the inspector: observed nursing equipment and nursing supply storage areas, reviewed resident's health care records, supply order lists, suction machine audits, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of resident #001.

The Ministry of Health and Long-term Care (MOHLTC) received an anonymous

complaint on an identified date in August 2018, indicating that resident #001 passed away due to improper care after a nurse could not locate the required equipment to treat the resident.

A review of resident #001’s progress notes indicated that on a second identified date and shift in August 2018, a PSW reported to registered nurse (RN) #112 at an identified time that resident #001 was in medical distress. The RN #112 immediately attended to resident #001, and while attempting to assess the resident, resident #001's condition worsened requiring emergency nursing care. RN #112 left the resident with the PSW and went to get an identified device to treat the resident; however, a specific piece of equipment was missing from the device setup rendering it unable to be used. RN #112 checked both their identified unit and a second identified unit for the required piece without success. Five minutes later, the RN returned to resident #001 and the resident was not responding. An identified code was called, emergency treatment was initiated, and paramedics were notified. Fifteen minutes later, firemen arrived and took over the resident's emergency care. The resident passed away.

During an interview, RN #112 indicated that prior to the incident resident #001 was at their baseline, and confirmed the above record review. RN #112 indicated that the incident happened very quickly and they did not think that the outcome would have changed had they been able to immediately locate the identified piece of equipment. RN #112 indicated further that there were identified devices on each floor for emergency use, and that the nursing staff were responsible to ensure that there were adequate supplies stocked on the units each shift for these devices.

During interviews, ADOC #108 and evening nurse manager (NM) #107 confirmed that there were identified devices on each unit for emergency use, one in an identified area on the main floor, and that each resident with a specific care need had their own designated device at their bedside.

ADOC #108 indicated that they were responsible for ordering supplies and that there were always supplies available for the identified care within the home. ADOC #108 indicated further that it was the charge nurse’s responsibility to check their home area at the start of their shift to ensure the equipment was available and in working condition.

During an interview, NM #107 indicated that they were responsible for auditing the device on the main floor monthly using a specific auditing tool and restocking the associated supplies. During the identified code they would go to the identified area on the main floor

to get that device because they knew it had been tested and was functional. NM #107 confirmed that they were not aware of an auditing tool being used by nursing staff on the units to check the identified equipment.
NM #107 indicated further that they were called on the identified date and shift by RN #112 who requested a specific piece of equipment. NM #117 responded to this request and the identified code by bringing specific emergency supplies and devices including the missing piece of equipment to resident #001's room. NM #107 confirmed that the required piece of equipment was not readily available to meet the needs of resident #001 who required emergency nursing care.

During the course of the inspection, the identified devices in the supply storage area on the primary unit and in the identified area on the main floor were observed and noted to include all of the required supplies for immediate use. There was no device observed in the supply storage area on a second identified unit. According to RN #110 the identified device on the secondary unit was not functioning and had been removed a few days prior for servicing. In an emergency, RN #110 indicated they had accessed the identified device from the primary unit which had included all of the required parts.

During an interview, the DOC indicated they were not aware of any issues regarding availability of equipment on the date of resident #001's death. The DOC confirmed that based on RN #112's documentation, the required equipment for the identified emergency nursing care was not there when it was needed for resident #001. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.