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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 24, 2019	2019_642698_0007	003924-18, 004280-18, 005044-18, 006389-18, 009243-18, 009538-18, 009548-18, 010370-18, 011054-18, 016106-18, 016419-18, 017890-18, 018338-18, 024184-18, 029577-18, 031917-18, 001131-19, 001624-19	Critical Incident System

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

ORALDEEN BROWN (698), ADAM DICKEY (643), IVY LAM (646), JOANNE ZAHUR (589), PRAVEENA SITTAMPALAM (699)

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): April 18, 23-26, 29-30, May 1-3, and 6-10, 2019.

Log # 003924-18, CIS #2594-000012-18; Log # 001624-19, CIS #2594-000005-19; and Log # 018338-18, CIS # 2594-000050-18 related to responsive behavior;
Log # 005044-18, CIS # 2594-000018-18; Log # 017890-18, CIS #2594-000049-18; Log # 009548-18 and Log # 029577-18 related to falls;
Log # 010370-18, CIS #2594-000032-18; Log # 016419-18, CIS # 2594-000048-18; Log # 024184-18, CIS #2594-000057-18; and Log # 001131-19, CIS #2594-000003-19 related to transferring;
Log # 011054-18, CIS #2594-000037-18; related to infection prevention and control;
Log # 009243-18, CIS #2594-000030-18 related to unexpected death;
Log # 009538-18, CIS #2594-000031-18; and Log # 016106-18, CIS #2594-000045-18 related to neglect;
Log # 004280-18, CIS #2594-000013-18; Log 006389-18, CIS #2594-000021-18; Log # 031917-18, CO#001 from inspection #2018_751649_0019 related to abuse including one follow-up.

A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c. 8, s. 6(10) (b) identified in concurrent inspection 2019_642698_0006 (Log #005435-19) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Manager of Long Term Care Performance and Capacity Toronto Central LHIN, Registered Psychological Consultant Behavioral Support Ontario (BSO) Coordinator, Physiotherapist /Falls Lead, Environmental Service Supervisor (ESS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_751649_0019	643

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	Légende 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure staff used safe transferring techniques when assisting residents.

a. A Critical Incident Systems (CIS) was submitted to the Ministry of Health and Long

Term Care (MOHLTC) on an identified date, for an incident that occurred on the same day. The CIS report indicated that two PSW's had conducted a manual transfer of resident #006 from bed to a mobility device noting an identified injury to resident #006. This incident was reported to the RN who applied a dressing to the injury and called 911 for the resident's transfer to hospital.

A review of resident #006's care plan in place at the time of this incident indicated that a transferring device was required using two staff for transfers. Further review of resident #006's health record indicated that they required manual transfer with two staff assistance. However, the care plan and kardex was revised and updated to indicate the use of a transferring device for transfers with two person assistance on an identified date.

A review of the Long Term Care Home's (LTCH) internal investigation notes indicated during interviews with PSW #109 and #117, they stated that they were unaware of resident #006 requiring a transferring device. Further review indicated that PSW #109 noted that after PSW #117 had repositioned resident #006 into bed, an injury was noted to an identified body part. In interviews, PSW #117 also stated that after PSW #109 entered the room, they proceeded to reposition resident #006 into a sitting position and noticed the injury. Both PSWs continued to transfer resident #006 into their mobility device and then notified the registered staff. These interviews also indicated that the mobility device had been placed close to the bed and may have caused the injury to resident #006.

During an interview, PSW #109 stated that PSW #117 was their work partner and therefore went to assist with transferring resident #006 from one area to the mobility device. PSW #109 acknowledged they had completed a two person transfer manually, as they were unaware that resident #006 required a transferring device. PSW #109 also stated that an injury occurred to the resident during the transfer.

During an interview, PSW #117 stated they were absent from work for a particular period of time and returned on an identified date. PSW #117 further stated they had not been aware of changes in resident #006's transferring needs requiring a transferring device. An identified date indicated that PSW #117 had been provided orientation to familiarize themselves with their resident assignment and any changes to resident care needs. PSW #117 further confirmed they should have reviewed resident #006's care plan/kardex prior to providing care and as a result, completed an unsafe transfer.

Further review of the LTCH's investigation notes indicated that PSW #109 and #117 received disciplinary action related to resident #006 provision of care as per their plan of care, as well as conducting an unsafe transfer.
During an interview, DOC #104 acknowledged that PSW #109 and #117 had not provided care to resident #006 as per their plan of care and therefore failed to ensure safe transferring techniques were used when assisting resident #006.

b. CIS report was submitted to the MOHLTC on an identified date for an incident that occurred on an identified date. The CIS report indicated that on an identified date, resident #013 had been incontinent while in an identified area of the Long Term Care Home (LTCH) and required care. PSW #105 was assisted by two other staff members in transferring resident #013 from their mobility device to another using a transferring device.

A review of resident #013's plan of care at the time of the incident indicated that they required a two person assist using a transferring device and a specified size sling for transfers.

A review of the LTCH's investigation notes indicated during an interview with PSW #105, they acknowledged that they had not called for assistance when resident #013 needed to be transferred from the mobility device to their bed. The LTCH's investigation notes also indicated that PSW #105 received disciplinary action related to conducting an unsafe transfer with the transferring device.

During an interview, PSW #105 stated that they left the resident care area after two other staff members had assisted with the initial transfer from one mobility device to another. PSW #105 further stated that after care was completed, they did not call for assistance as the other staff members were busy at the time and that resident #013 was being uncooperative. Using the transfer device, they solely decided to complete the transfer from one mobility device to the resident's bed unassisted. PSW #105 acknowledged they should have asked for assistance as resident #013's care plan indicated two staff transfer using a transferring device.

During an interview, NM #107 acknowledged that PSW #105 had used unsafe transferring techniques with the transferring device when assisting resident #013 back to bed on an identified date.

c. A CIS report was submitted to the MOHLTC. The CIS report indicated that on an

identified date, resident #013 approached Registered Practical Nurse (RPN) #102 reporting that on the previous evening PSW #108 dropped them on the floor while transferring them from their mobility device onto the bed using a transferring device unassisted.

At the time of the incident, a review of resident #013's plan of care and Kardex indicated that they required two person assistance with a transferring device and a specified size sling for transfers.

A review of the LTCH's policy titled: Zero Lift & Protocol, current revised on an identified date, indicated under the team member will: comply with the Zero Lift & Protocol policy, procedures, and care plan/service plan at all times by utilizing appropriate body mechanics, available lift devices, and seeking additional assistance where required. Note: Two (2) qualified team members must be present at all times when operating a lift equipment.

A review of the LTCH's internal investigation indicated that during an interview PSW #108 denied transferring resident #013 unassisted, insisting they had assistance. However, they could not state who actually had been present. The internal investigation also indicated Closed Circuit Television (CCTV) footage from the evening on an identified date, indicating PSW #108 entering and exiting resident #013's alone with the transferring device. The LTCH could not provide this footage during this inspection. However, they were able to provide CCTV footage from the previous evening, which also indicated PSW #108 entering resident #013's room alone with the transferring device. The LTCH's internal investigation concluded that PSW #108 was using the transferring device alone and in fact had been using this device alone on several occasions as verified by interviews conducted with co-workers. The LTCH's investigation notes also indicated that PSW #108 received disciplinary action related to conducting an unsafe transfer with the transferring device.

During interviews, PSW #112 and #115 acknowledged that on an identified date, PSW #108 had not asked them for any assistance with transferring resident #013. PSW #115 stated they were partnered with PSW #108 and that they had not been asked by PSW #108 to assist with any resident transfers using a transferring device for quite some time now. PSW #115 further stated that PSW #108 prefers to work alone.

During an interview, PSW #108 acknowledged to the inspector they had completed the transfer of resident #013 on an identified date, unassisted. PSW #108 further stated they

knew they were not using safe transferring techniques but that they were trying to meet the needs of resident #013 who insisted on going to bed.

During an interview, Assistant Director of Care (ADOC) acknowledged that PSW #108 had used unsafe transferring techniques with the transferring device when assisting resident #013 to bed on an identified date. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

CIS report was submitted to the MOHLTC on an identified date. The CIS report indicated that on an identified date, resident #013 had been transferred to bed and while PSW

#105 was removing the transferring device from underneath the resident they struck an identified body part on the side rail resulting in an identified injury.

A review of resident #013's plan of care indicated that they required two person assist during repositioning in bed using side rails.

During an interview, PSW #105 stated they provided care for resident #013 and they had the assistance of two other PSWs to transfer the resident to the mobility device. Once resident #013 was in bed, PSW #105 stated they were attempting to remove the transferring device unassisted and that resident #013 was moving around. PSW #105 further stated they had asked resident #013 to slow down but they kept moving up and down in their bed and then struck an identified area of their body on the side rail resulting in injury. PSW #105 acknowledged there should have been two staff present to remove the device.
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A review of the LTCH's internal investigation notes indicated that once resident #013 was transferred back to bed after being cared for, the resident was moving themselves from side to side when the injury occurred. PSW #105 further acknowledged during an interview they should have had the assistance of another staff member when removing the transfer device while resident #013 was in bed.

During an interview, NM #107 acknowledged that resident #013's plan of care indicated two person assistance and that PSW #105 had not provided care as specified in the plan of care. [s. 6. (7)]

2. CIS report was submitted to the MOHLTC on an identified date, related to suspected neglect of resident #015.

Review of resident #015's health records showed that they had returned from hospital on an identified date, with impaired skin integrity to an identified area of the body. Resident #015 was assessed by RPN #120 who was the home's wound care nurse on an identified date, and a recommendation was made to continue to turn and position the resident every two hours.

Review of resident #015's plan of care showed that the resident required the assistance of two staff members for bed mobility. Resident #015 required assistance turning and repositioning at least every two hours.

Review of the home's investigation showed that PSW #129 indicated they had turned and positioned resident #015 at an identified time and did not ask for assistance from another staff member. Review of Point Of Care (POC) follow-up question documentation showed PSW #129 documented that resident #015 was totally dependent on staff for turning and positioning with one staff member assistance on an identified date.

In an interview, PSW #129 indicated that they turned and repositioned resident #015 every two hours and used pillows to keep resident from rolling back. PSW #129 indicated that they were able to handle resident #015's care alone, and acknowledged that they were not aware at the time that the plan of care indicated two staff members were to assist with bed mobility. PSW #129 indicated that they turned and positioned resident #015 alone which was not according to the resident's plan of care.

Review of the CIS report showed that at an identified time on an identified date, RPN #102 discussed resident #015's required turning and positioning with PSW #129. The CIS further indicated that PSW #129 stated it was difficult to reposition the resident and RPN #102 instructed the PSW to get another staff to assist.

In an interview, the DOC indicated that PSW #129 had not been aware of resident #015's care plan requirements and provided turning and positioning assistance without the help of another staff member. The DOC indicated that PSW #129 received discipline as a result of this incident. The DOC acknowledged that PSW #129 did not provide care to resident #015 as specified in the plan. [s. 6. (7)]

3. The MOHLTC received a CIS report related to the unexpected death of resident #018 on an identified date.

Record review of resident #018's advanced directive identified a specified level of care. Record review of resident #018's progress notes indicated that on an identified date, the physician ordered a specified sample to be collected on a particular date. Review of the progress notes on an identified date, indicated that resident #018 had symptoms and interventions were done on an identified date. Further review of the progress notes did not indicate whether interventions were done during a certain time period. On a particular date, a procedure was ordered and an intervention was done on a later identified date. Resident #018's procedure results returned and indicated that resident had an identified diagnosis and treatment commenced on an identified date.

In an interview with RPN #147 and #146, they stated that the test procedure should have been done on an identified date. They further stated there should have been communication in the progress notes and nursing communications to alert that staff were unable to carry out the procedure. RPN #147 acknowledged that resident #018's plan of care was not followed.

In an interview with DOC #104, they stated staff could have attempted the test procedure. However, the expectation would be for staff to document their attempts. They further stated resident #018's plan of care was not followed as there was no documentation of possible attempts to carry out the procedure. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

CIS report was submitted to the MOHLTC on an identified date, related to suspected neglect of resident #012 by staff in the home. According to the CIS report, resident #012 reported to RPN #102 that RN #118 had refused to administer a specified drug on an identified date.

In an interview, resident #012 indicated that they recalled an incident with RN #118, and had complained to management that the RN was not truthful regarding the administration of a specified drug.

Review of resident #012's Medication Administration Record (MAR) for an identified date showed an order for specified drug to be administered by mouth (PO) as needed (PRN) at a specified time. The MAR did not show documentation that the specified drug was administered by RN #118 on an identified date.

Review of the home's investigation notes showed that an interview was carried out with RN #118 in which they told the DOC they had administered the specified drug, but had not documented on resident #012's electronic MAR (eMAR) or on the effectiveness of the PRN medication. RN #118 was not available for interview at the time of the inspection.

In an interview, the DOC indicated that the expectation of the home was for registered staff to document on the resident's eMAR every administration of medication including a

PRN. The DOC indicated that the investigation showed that RN #118 did not document on the administration of resident #012's specific drug on an identified date, and could not prove whether the medication was administered or not. The DOC acknowledged that the home failed to ensure that the provision of the care set out in the plan of care was documented.

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

a. CIS report was submitted to the MOHLTC on an identified date, related to resident #003's fall, where the resident sustained an injury, resulting in significant change to the resident's health status.

Review of the resident's post fall incident form, dated an identified date, showed that the resident was using their mobility device at the time of the fall. Review of resident #003's care plan, revised on an identified date, showed that the resident was care planned to use a different mobility device for locomotion.

Review of the progress notes showed that the Occupational Therapist (OT) had assessed the resident on an identified date, and had assessed that the resident was able to ambulate independently with a specified mobility device. Review of the Physiotherapist (PT) note on an identified date, showed that the PT had assessed the resident, and the resident was able to ambulate without issue.

Interview with RN #136 who updated resident #003's care plan on specified date, indicated that resident had an identified condition and may need to use a specific mobility device when their condition exacerbated, but could use another mobility device when their condition improved. The RN was unable to recall what led to the change of the care plan at the time, or why it was not updated after the OT and PT's assessments.

Interview with the PT indicated that at the time of resident #003's fall, the resident was able to ambulate independently with their mobility device. The PT further indicated that on an identified date, the resident was sent to hospital related to specified issues, and may have required a wheelchair upon their return. The PT continued to say that their condition had improved after returning from the hospital and was able to continue to use their mobility aid. The PT stated that the written plan of care needed to be updated to specify the changes in resident's care, including the discontinuation of mobility device.

Interview with the DOC stated that resident #003's care plan was not updated when the resident's care needs for locomotion changed.

b. In a concurrent Complaint inspection, the following evidence related to resident #025 was found under inspection report # 2019_642698_0006 (log #005435-19).

On an identified date, a complaint was received by the MOHLTC regarding concerns that resident #025 developed a specified condition which resulted in the resident passing away in the hospital on an identified date. Further review of the complaint indicated that resident experienced symptoms related to the specified condition that was not well managed and that family was not aware of the resident's condition until a physician informed them.

Record review of the progress notes indicated that on an identified date, the resident was sent to hospital for symptoms that was worsening. Further review of the progress notes indicated that the resident came back to the home four days later with a specified diagnosis.

Review of resident #025's hospital discharge summary on an identified date indicated that resident #025 had a specified condition to a particular area of the body. Review of resident #025's care plan did not indicate that resident #025 had this specific condition to that same area of the body.

Separate interviews with RPN #102 and RN #116, indicated that staff would refer to the care plan or documentation for resident related care. They indicated the expectation would be for the resident's care plan to be updated with any altered skin integrity issues.

Review of the home's policy titled Skin and Wound Care Management Protocol, indicated that any resident exhibiting altered skin integrity would have their plan of care, including the Treatment Administration Record (TAR) and care plan, updated as required.

In an interview with DOC #104, they indicated the expectation would be for the resident's care plan to be updated with any altered skin integrity issues. The DOC acknowledged that for resident #025, their care plan was not updated to reflect the specific conditions on that particular area of the body. [s. 6. (10) (b)]

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 the care set out in the plan of care is provided to the resident as specified in the plan; ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are free from neglect by the licensee or staff in the home.

The MOHLTC received a CIS report related to the unexpected death of resident #018 on an identified date.

Record review of resident #018's progress notes by RPN #144 indicated on an identified date, resident #018 was seen in distress during medication administration. Vital signs were completed and the resident was stable at that time. Further review of RPN #144 progress notes indicated RPN #145 was completing rounds at an identified time and informed RPN #144 that resident #018's condition was changing. RPN #144 went to assess the resident and confirmed the change in condition. RPN #144 called nursing manager (NM) #118 for assistance. NM #118 informed RPN #144 to call 911. RPN #144 called 911 and NM #118 arrived to the unit and went to assess resident #018. NM #118 returned to RPN #144 and informed RPN #144 that resident #018 was no longer

breathing and to cancel 911.

Review of the progress notes showed no documentation relating to an assessment of resident #018 by RPN #145 and NM #118. Review of additional progress notes showed that the physician pronounced the resident on an identified date.

In an interview with RPN #145, they stated if a resident was noted to have a change in health status, they would complete vital signs. They further stated if the vital signs were unsatisfactory, they would call the nurse manager, emergency and send the resident to hospital. RPN #145 stated a resident who was in distress cannot be left alone. They stated when a resident is found unresponsive or without vital signs, a code blue would be called, the resident's care directive would be checked, CPR initiated, if required and 911 called. RPN #118 stated they arrived to the unit on an identified date, a half an hour early prior to starting their shift when they were informed by a PSW that resident #018 was in distress. They completed vital signs and noted that the resident's vitals were abnormal. They informed RPN #144 who was still on duty. RPN #145 indicated they left resident #018 in the room alone and acknowledged they were at fault. They further stated that they should have stayed with the resident, provide treatment, call 911 and initiate code blue if the resident became unresponsive. RPN #145 acknowledged the resident was not provided the care that they required and the event was neglectful.

Inspector #699 was unable to reach RPN #144 or NM #118 for an interview.

Review of the home's investigation notes indicated that RPN #144 received report from RPN #145 at an identified time regarding resident #018's change in condition and RPN #144 went to assess the resident. Upon assessment, RPN #144 noted resident #018's abnormal vitals. RPN #144 went to the nursing station and called NM #118 who instructed RPN #144 to call 911. NM #118 arrived to the floor at 2300 hrs and inquired from RPN #144 what resident #018's advance directives were. RPN #144 informed NM #118 of the level. NM #118 went to resident #018's room and returned to RPN #144 and stated that resident #018 was not breathing and to cancel 911. NM #118 took the phone from RPN #144 and cancelled the ambulance. NM #118 provided report to oncoming staff and left the building. RPN #144 called PGT, MD, completed documentation and reported event to oncoming NM.

Further review of investigations did not indicate that a staff member remained with resident #018 when it was noted resident was in distress. NM #118 and RPN #145 was diciplined related to not providing appropriate care to resident #018.

Review of the home's policy titled "Do Not Resuscitate - Cardiopulmonary Resuscitation (CPR)" indicated that in the absence of a do not resuscitate (DNR) order or an expressed wish not be resuscitated, team members will consider whether the use of CPR is appropriate to the situation based on the following factors:
-the arrest was witnessed or occurred within minutes of the resident seen functioning normally.

In an interview with DOC #104, they stated if a resident is found unresponsive, their advance directive would direct the staff on what to do. They further stated that not providing treatment or care for a resident would be considered neglectful. DOC #104 acknowledged that resident #018 was not provided the care they required. [s. 19. (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 residents are free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The MOHLTC received a CIS report related to the unexpected death of resident #018 on an identified date.

Record review of resident #018's advance directive identified a specified level of care.
Review of progress notes on an identified date, indicated that resident #018 had specified symptoms and specific procedures were done on a specified date.
Review of the progress note on an identified date, indicated resident #018's results came in and indicated the resident had a specific symptom and was started on specified treatments on an identified date.

Record review of the progress notes indicated on identified dates, monitoring was not completed.

In an interview with RPN #147 and #146, they stated that if a resident has an identified symptom, they would be monitored daily. They further stated that vital signs would be completed every shift as part of monitoring. They acknowledged for the above mentioned days, resident #018 was not monitored for their these specific signs and symptoms.

In an interview with DOC #104, they stated that the expectation for staff is to monitor residents every shift if they have an identified symptom. The DOC acknowledged for the above mentioned dates, resident #018 was not monitored for the signs and symptoms. [s. 229. (5) (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 monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 3rd day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ORALDEEN BROWN (698), ADAM DICKEY (643), IVY LAM (646), JOANNE ZAHUR (589), PRAVEENA SITTAMPALAM (699)
Inspection No. / No de l'inspection :	2019_642698_0007
Log No. / No de registre :	003924-18, 004280-18, 005044-18, 006389-18, 009243-18, 009538-18, 009548-18, 010370-18, 011054-18, 016106-18, 016419-18, 017890-18, 018338-18, 024184-18, 029577-18, 031917-18, 001131-19, 001624-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 24, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	St. George Care Community 225 St. George Street, TORONTO, ON, M5R-2M2

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : John Seebach

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To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee shall:

a) ensure PSWs #105, #108, #109, and #117 and any other PSWs are provided education on safe transferring, positioning devices or techniques and on strategies to request assistance without leaving a resident's side when providing care and assistance,
b) Provide training to the above staff members on the importance of being familiar with and following resident care plans related to transferring methods used in the home and
c) develop and implement a documented auditing system that consists of audits of PSW staff, specifically, that PSW's #105, #108, #109, and #117 and all other PSW staff, are using safe transferring and positioning devices or techniques when assisting residents. The audits should include the date of the audit, who completed the audit, the outcome of the audit and any actions taken as a result of the audit; keep a documented record of education sessions provided that includes the material covered, date(s) of when the education was provided, staff that attended and who provided the education sessions.

Grounds / Motifs :

1. 1. The licensee failed to ensure staff used safe transferring techniques when assisting residents.

a. A Critical Incident Systems (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, for an incident that occurred on the same day. The CIS report indicated that two PSW's had conducted a

manual transfer of resident #006 from bed to a mobility device noting an identified injury to resident #006. This incident was reported to the RN who applied a dressing to the injury and called 911 for the resident's transfer to hospital.

A review of resident #006's care plan in place at the time of this incident indicated that a transferring device was required using two staff for transfers. Further review of resident #006's health record indicated that they required manual transfer with two staff assistance. However, the care plan and kardex was revised and updated to indicate the use of a transferring device for transfers with two person assistance on an identified date.

A review of the Long Term Care Home's (LTCH) internal investigation notes indicated during interviews with PSW #109 and #117, they stated that they were unaware of resident #006 requiring a transferring device. Further review indicated that PSW #109 noted that after PSW #117 had repositioned resident #006 into bed, an injury was noted to an identified body part. In interviews, PSW #117 also stated that after PSW #109 entered the room, they proceeded to reposition resident #006 into a sitting position and noticed the injury. Both PSWs continued to transfer resident #006 into their mobility device and then notified the registered staff. These interviews also indicated that the mobility device had been placed close to the bed and may have caused the injury to resident #006.

During an interview, PSW #109 stated that PSW #117 was their work partner and therefore went to assist with transferring resident #006 from one area to the mobility device. PSW #109 acknowledged they had completed a two person transfer manually, as they were unaware that resident #006 required a transferring device. PSW #109 also stated that an injury occurred to the resident during the transfer.

During an interview, PSW #117 stated they were absent from work for a particular period of time and returned on an identified date. PSW #117 further stated they had not been aware of changes in resident #006's transferring needs requiring a transferring device. An identified date indicated that PSW #117 had been provided orientation to familiarize themselves with their resident assignment and any changes to resident care needs. PSW #117 further confirmed they should have reviewed resident #006's care plan/kardex prior to

providing care and as a result, completed an unsafe transfer.

Further review of the LTCH's investigation notes indicated that PSW #109 and #117 received disciplinary action related to resident #006 provision of care as per their plan of care, as well as conducting an unsafe transfer.
During an interview, DOC #104 acknowledged that PSW #109 and #117 had not provided care to resident #006 as per their plan of care and therefore failed to ensure safe transferring techniques were used when assisting resident #006.

b. CIS report was submitted to the MOHLTC on an identified date for an incident that occurred on an identified date. The CIS report indicated that on an identified date, resident #013 had been incontinent while in an identified area of the Long Term Care Home (LTCH) and required care. PSW #105 was assisted by two other staff members in transferring resident #013 from their mobility device to another using a transferring device.

A review of resident #013's plan of care at the time of the incident indicated that they required a two person assist using a transferring device and a specified size sling for transfers.

A review of the LTCH's investigation notes indicated during an interview with PSW #105, they acknowledged that they had not called for assistance when resident #013 needed to be transferred from the mobility device to their bed. The LTCH's investigation notes also indicated that PSW #105 received disciplinary action related to conducting an unsafe transfer with the transferring device.

During an interview, PSW #105 stated that they left the resident care area after two other staff members had assisted with the initial transfer from one mobility device to another. PSW #105 further stated that after care was completed, they did not call for assistance as the other staff members were busy at the time and that resident #013 was being uncooperative. Using the transfer device, they solely decided to complete the transfer from one mobility device to the resident's bed unassisted. PSW #105 acknowledged they should have asked for assistance as resident #013's care plan indicated two staff transfer using a transferring device.

During an interview, NM #107 acknowledged that PSW #105 had used unsafe

transferring techniques with the transferring device when assisting resident #013 back to bed on an identified date.

c. A CIS report was submitted to the MOHLTC. The CIS report indicated that on an identified date, resident #013 approached Registered Practical Nurse (RPN) #102 reporting that on the previous evening PSW #108 dropped them on the floor while transferring them from their mobility device onto the bed using a transferring device unassisted.

At the time of the incident, a review of resident #013's plan of care and Kardex indicated that they required two person assistance with a transferring device and a specified size sling for transfers.

A review of the LTCH's policy titled: Zero Lift & Protocol, current revised on an identified date, indicated under the team member will: comply with the Zero Lift & Protocol policy, procedures, and care plan/service plan at all times by utilizing appropriate body mechanics, available lift devices, and seeking additional assistance where required. Note: Two (2) qualified team members must be present at all times when operating a lift equipment.

A review of the LTCH's internal investigation indicated that during an interview PSW #108 denied transferring resident #013 unassisted, insisting they had assistance. However, they could not state who actually had been present. The internal investigation also indicated Closed Circuit Television (CCTV) footage from the evening on an identified date, indicating PSW #108 entering and exiting resident #013's alone with the transferring device. The LTCH could not provide this footage during this inspection. However, they were able to provide CCTV footage from the previous evening, which also indicated PSW #108 entering resident #013's room alone with the transferring device. The LTCH's internal investigation concluded that PSW #108 was using the transferring device alone and in fact had been using this device alone on several occasions as verified by interviews conducted with co-workers. The LTCH's investigation notes also indicated that PSW #108 received disciplinary action related to conducting an unsafe transfer with the transferring device.

During interviews, PSW #112 and #115 acknowledged that on an identified date, PSW #108 had not asked them for any assistance with transferring resident

#013. PSW #115 stated they were partnered with PSW #108 and that they had not been asked by PSW #108 to assist with any resident transfers using a transferring device for quite some time now. PSW #115 further stated that PSW #108 prefers to work alone.

During an interview, PSW #108 acknowledged to the inspector they had completed the transfer of resident #013 on an identified date, unassisted. PSW #108 further stated they knew they were not using safe transferring techniques but that they were trying to meet the needs of resident #013 who insisted on going to bed.

During an interview, Assistant Director of Care (ADOC) acknowledged that PSW #108 had used unsafe transferring techniques with the transferring device when assisting resident #013 to bed on an identified date.

The severity of this issue was determined to be a level 3 as there was actual harm to the affected residents. The scope of the issue was a level 2 as it related to two of the three residents reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Oraldeen Brown

Service Area Office /
Bureau régional de services : Toronto Service Area Office