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_0006	004127-18, 006653-18, 024626-18, 005435-19, 005911-19, 006025-19, 007906-19	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

ORALDEEN BROWN (698), ADAM DICKEY (643), PRAVEENA SITTAMPALAM (699)

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

The following Complaint intakes were inspected during this inspection:

Log # 004127-18 related to multiple care areas;
Log # 006653-18 related to medication administration;
Log # 024626-18 related to alleged abuse;
Log # 005435-19 related to skin/wound neglect;
007906-19 related to withholding approval for admission
Log # 005911-19, IL-65116-TO and Log # 006025-19, CI 2594-000013-19 related to injury with unknown cause.

A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c. 8, s. 6(10) (b) identified in this inspection will be issued in concurrent inspection 2019_642698_0007 (Log #005435-19).

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) family members and residents.

During the course of the inspection, the inspectors conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to approve the applicant's admission to the home unless:
(a) the home lacked the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

A written notice withholding approval of applicant #023's application to the home was received by the Ministry of Health and Long Term Care (MOHLTC) on an identified date. The letter indicated that the application was being withheld as circumstances existed which were provided for in the regulations as being a ground for withholding approval. The written notice further indicated that due to severe responsive behaviours the applicant posed a risk to self and others.

Review of applicant #023's InterRAI assessment form with assessment referenced on an identified date, showed that no behaviors were noted and the applicant was discharged by the behavioural outreach team as there were no behavioural concerns. Review of applicant #023's Behavioural Assessment Tool (BAT) dated an identified date, showed the applicant had gone from being mobile to bedbound in the last eight to nine months. The BAT further showed that there were no new or ongoing behaviours exhibited in the last nine months, and no new behaviours were noted or reported.

In an interview, Manager of Long-Term Care Performance and Capacity from Toronto Central Local Health Integration Network (LHIN) indicated that the applicant had been living with strategies in place to manage their behaviours. The Manager indicated the behavioural assessment by an identified behavioral outreach team showed the applicant was coping well with no new behaviours. The manager indicated applicant #023 was on a crisis placement for Long-Term Care. The manager indicated that they had forwarded the written notice to the MOHTLC as they did not believe the home provided a valid reason according to the legislation.

In an interview, the DOC indicated that they had reviewed the application for applicant #023 and believed that the applicant posed a significant risk due to responsive behaviours. The DOC was unable to indicate where the grounds were noted in the regulations for withholding applicant #023's application. The DOC indicated they had not been aware of some of the information on an identified date, in the InterRAI assessment and BAT tools and that the applicant had not exhibited behaviours in the last eight to nine months. The DOC indicated that based on discussion with the inspector they would ask the LHIN placement coordinator to re-submit applicant #023's application to the home. The DOC acknowledged that a ground for withholding approval for applicant #023 was not provided for in the regulations.
[s. 44. (7)]

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 with ensuring that the appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43. (6), and the licensee shall review the assessments and information and shall approve the application's admission to the home unless:
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On an identified date, a complaint was received by the MOHLTC regarding concerns that resident #025 developed a specified condition on an area of their body which resulted in the resident expiring in the hospital on an identified date.

Review of the resident #025's clinical health record indicated the resident had the following specified diagnoses.

Record review of resident #025's progress notes indicated that on an identified date, the resident was sent to hospital for signs and symptoms that were worsening. Further review of the progress notes indicated that the resident returned to the home on an identified date with a specified diagnosis. Review of the progress notes, indicate that resident #025 was observed having altered skin integrity over a three month period. During this time period, the resident experienced a change in condition, was seen by the physician three weeks later since onset, and was seen two months later by a specialist.

Record review of resident #025's assessments in PointClickcare (PCC) indicated on specified dates, skin and wound assessments were completed. Further review of the assessments indicated that within the above mentioned time period, there were no skin assessments initiated for the above mentioned areas of altered skin integrity.

In an interview with RPN #102, they stated any form of impairment or alterations to the normal skin of a resident would require assessment and weekly. RPN #102 stated that for resident #025, a skin and wound assessment should have been initiated when the impairment was noted.

In an interview with wound care RN #116, they stated weekly monitoring was expected for resident #025. RN #116 acknowledged that interventions were not completed for resident #025 specified condition.

Review of the home's policy titled Skin and Wound Care Management Protocol, indicated that any resident exhibiting altered skin integrity will have a skin and wound assessment completed.

In an interview with DOC #104, they stated that when a resident exhibits altered skin integrity, assessment would be initiated and subsequently monitored weekly. They acknowledged for resident #025, assessments were not completed for their specified condition. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home, and implemented any changes made to the plan of care related to nutrition and hydration.

Record review of resident #025's progress notes indicated that over a three month period, the resident was referred to the Registered Dietician (RD) three times. Further review of resident #025's chart, did not indicate that resident #025 was referred to the RD nor was an assessment of nutrition status carried out for their specified condition. [s. 50. (2) (b) (iii)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

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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.