Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 6, 2019	2019_630589_0023	009222-19, 010475-19, 010726-19, 011156-19, 018883-19	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

JOANNE ZAHUR (589), NATALIE MOLIN (652)

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): October 15, 16, 17, 18, 21, 22, 23, 24, & 25, 2019.

During this inspection the following intakes were inspected:
-log #009222-19 and log #010475-19 related to improper care,
-log #018883-19 and log #010726-19 related to falls prevention, and
-log #011156-19 related to compliance order #001 follow-up inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nursing staff (RN/RPN), Personal Support Workers (PSW), Social Worker (SW), Office Manager (OM), and Residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, and the provision of care, reviewed health records, staff education attendance records, education materials provided and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)**

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
O.Reg 79/10 s. 36.	CO #001	2019_642698_0007	589

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. 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).

Findings/Faits saillants :

The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

Two Critical Incident System (CIS) reports were submitted to the Director related to the same incident that had occurred on an identified date in April 2019. The CIS reports indicated that staff #102 had provided personal care to resident #001 unassisted and as a result an incident occurred where the resident sustained an injury.

During an interview, staff #104 stated they had submitted the second CIS report for the same incident as their internal investigation had concluded that staff #102 had neglected resident #001.

A review of the Long-Term Care Homes (LTCH) investigation notes indicated that staff #102 did acknowledge they had made a mistake and had been alone in the room with resident #001 when providing personal care. The investigation notes further indicated that staff #102 had been disciplined and was required to complete education prior to resuming their duties.

A review of resident #001's care plan indicated under the Activities of Daily Living (ADL) focus, that when providing care, two staff are to be present to ensure the safety of the resident.

During an interview, staff #102 stated they were nervous and had not initially acknowledged to the registered staff that they had been providing care alone, but instead stated a co-worker had been helping them. Staff #102 acknowledged to the inspector they had made a mistake, as they had been providing care unassisted to resident #001.

During an interview, staff #103 stated that when they were called to resident #001's room, they observed staff #102 in the room alone with resident #001. Staff #110 stated during an interview, that staff #102 had not asked them to provide any assistance with resident #001's care that day.

During an interview, staff #104 acknowledged that staff #102 had not provided care to resident #001 as specified in their plan of care.

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 the care set out in the plan of care was provided as specified in the plan, to be implemented voluntarily.

Issued on this 12th day of November, 2019

[redacted]

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

Original report signed by the inspector.