Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 16, 2021	2021_769646_0014	002468-21, 005828-21	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

IVY LAM (646)

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): July 29 and 30; August 3, 4, 5, 6, 9, 10, 11, 12, 13, and 16, 2021.

The following complaint intakes were completed during this inspection:

Log # 002468-21 related to nutrition and hydration care, quality of food, weight change, change in condition, and falls prevention; and
Log #005828-21 related to skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Director of Food Service, Program staff, Supervisor of Housekeeping and Laundry, Maintenance staff, Dietary Aides, Infection Prevention and Control (IPAC) lead, Building Services Partner, Falls Lead, Physiotherapist (PT), Substitute Decision Makers, Complainant, and Residents.

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 :

1. The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of one resident's plan of care.

A complaint was received regarding the SDM not being informed of the resident requiring the use of an assistive mobility device until after the resident had a fall.

A Registered Practical Nurse (RPN) documented that the resident had a change in ambulation status and was provided an assistive mobility device (ADM). The Physiotherapist's (PT) assessment completed on the same day showed the resident an ADM from the home. The RPN also indicated the resident mostly remained on their ADM. A PT assessment six days later, showed the resident remained in their ADM due to difficulty with ambulation.

The resident's two SDMs were contacted on the third and fourth days after the resident began to use the ADM, but there was no documentation that the SDMs were informed of the resident's change in ambulation status or use of an ADM. The resident had a fall from their ADM eight days after they were provided the assistive mobility device, and the SDM was informed of the fall.

Another RPN indicated that they had noticed the resident had a change in ambulation status and had offered the resident an ADM. They indicated they would usually inform

the SDM of this change and would document the communication in the progress notes.

The Director of Care (DOC) indicated there was no record of communication with the resident's SDM(s) until after they had a fall from their ADM.

[Sources: Resident's progress notes, care plan, MDS, physiotherapist assessments, risk management notes; Interviews with the complainant, PT, RPNs, DOC, and other staff.] [s. 6. (5)]

2. The licensee has failed to ensure that one resident's plan of care was reviewed and revised when the resident's care needs changed.

A resident had a fall and was assessed by the PT on two days later and a falls prevention intervention was recommended for the resident. The resident had another fall five days after the first fall.

The resident's falls prevention intervention was not added to their care plan until ten days after the PT's recommendation.

An RPN indicated the care plan should have been updated on the day the PT recommended the intervention and was not sure why it was not.

The DOC indicated the resident's care plan should have been updated when the resident's care needs changed, and when the intervention was recommended by the PT.

There was a risk that the resident would not be provided with their recommended falls prevention intervention when it was not included in the resident's care plan when first recommended.

[Sources: Resident's progress notes, care plan, physiotherapist assessments, risk management notes, Documentation Survey Report v2; Interviews with the complainant, RPNs, DOC, and other staff.] [s. 6. (10) (b)]

Issued on this 1st day of October, 2021

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

Original report signed by the inspector.