Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 6, 2023	
Inspection Number: 2023-1107-0001	
Inspection Type: Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: St. George Care Community, Toronto	
Lead Inspector Noreen Frederick (704758)	**Inspector Digital Signature**
Additional Inspector(s) Rodolfo Ramon (704757)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 2023

The following intake(s) were inspected:

- Intake: #00006422 - [CI: 2594-000005-22] Improper administration of drugs
- Intake: #00008018 - [CI: 2594-000023-22] Unknown etiology fracture
- Intake: #00012168 - [CI: 2594-000028-22] Witnessed fall with fracture
- Intake: #00015043 - [CI: 2594-000030-22] Allegation of Abuse
- Intake: #00002568 - [CI: 2594-000015-22] Allegation of Neglect
- Intake: # 00006696- [CI: 2594-000011-22] Allegation Abuse

The following intake(s) were completed:

- Intake: #00001921 - [CI: 2594-000016-22] Unknown etiology fracture
- Intake: #00005514 - [CI: 2594-000002-22] Unwitnessed fall with fracture
- Intake: #00008142 - [CI: 2594-000024-22] Unwitnessed fall with fracture
- Intake: #00016559 - [CI: 2594-000031-22] Witnessed fall with fracture
- Intake: #00019064 - [CI: 2594-000003-23] Unwitnessed fall with fracture

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The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home, specifically the Minister's Directive: COVID-19 response measures for long-term care homes, as it pertains to universal masking.

Rationale and Summary
During IPAC observations conducted in the home, multiple staff were observed entering the building and proceeding to resident areas without wearing their mask. The IPAC Lead verified during an interview that upon entering the building, staff were required to discard their old mask and apply a new one immediately after.

Failing to comply with universal masking requirements placed residents, staff and visitors at risk of acquiring infectious diseases.

Sources: IPAC observations, IPAC Lead interview.
[704757]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a

resident as specified in the plan.

Rationale and Summary
(i) The resident's care plan indicated that they required two-person assistance for their personal hygiene due to responsive behaviours.

A Personal Support Worker (PSW) stated that they alone provided care to the resident. ADOC acknowledged that the resident was not provided with two staff assistance as specified in their care plan.

Failure to ensure that the resident was provided with care as set out in their care plan, placed the resident at risk for a potential injury.

Sources: resident 's care plan, and interviews with PSW and ADOC.
[704758]

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

Rationale and Summary
(ii) The resident's care plan indicated that they required an intervention when they are using their assistive device due to their high risk for falls.

On an identified date, the resident was observed with no intervention and Registered Practical Nurse (RPN) acknowledged that the resident did not have this intervention however, they initiated the intervention after inspector's observations. Care Support Assistant (CSA) stated that when they took the resident for a planned activity, they did not have the intervention in place.

Associate Director of Care (ADOC) acknowledged that the resident was not provided with an intervention as specified in their care plan.

Failure to provide an intervention to the resident, increased their risk of a potential fall.

Sources: inspector's observation, interviews with CSA, RPN, and ADOC, and resident's care plan.
[704758]

The licensee has failed to ensure that the plan of care was followed for resident #005 and #007.

Rationale and Summary
(iii) Critical Incident System (CIS) reports #2594-000011-22 and #2594-000015-22 were submitted to the MLTC.

During incident in CIS #2594-000011-22, an altercation took place between resident #005 and a staff. The Executive Director (ED) conducted an investigation of the incident which revealed that resident #005 was not offered their preferred supplies. According to resident #005's plan of care, they were required to be offered these supplies during care.

CIS #2594-000015-22 was also submitted related to concerns with the care provided to resident #007. The resident 's care plan stated that they required two-person assistance. ADOC verified during an interview that the care was not provided as specified in the resident's care plan.

Failing to follow the plan of care for resident #005 and #007 placed both residents at risk of not having their needs met.

Sources: Investigation notes for CIS #2594-000011-22 and #2594-000015-22, resident #005 and #007's plan of care, interviews with the ED and ADOC .
[704757]

WRITTEN NOTIFICATION: Policies and Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk for injury.

O. Reg. 246/22, s. 11 (1) (b) requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

Specifically, staff did not comply with home's policy "Falls Prevention & Management" (VII-G-

30.10, last revised 12/2021) which was included in the licensee's Fall Prevention & Management Program.

Rationale and Summary
A resident had an unwitnessed fall. Post fall assessment indicated that Head Injury Routine (HIR) was not initiated after the fall. The LTCH's "Falls Prevention & Management" policy stated, "Initiate a head injury routine if the resident fall is un-witnessed". RPN stated that they did not complete the HIR. ADOC/Falls Lead verified that staff were expected to initiate HIR per the home's policy.

Failing to comply with the LTCH's policy put the resident at risk for delayed identification of changes to the resident's health status following a fall.

Sources: The home's policy "Fall Prevention & Management" (VII-G-30.10, last revised 12/2021), resident's clinical records, and interview with RPN, and ADOC.
[704758]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the planned care intervention was included in a resident's written plan of care.

Rationale and Summary
A resident had an intervention initiated several months prior to this inspection. RPN #101, and #103 stated that they did not update the resident's care plan. ADOC/Falls Lead verified that staff were expected to update the care plan with this planned intervention.

Failure to update the resident's care plan, increased the risk of staff not becoming aware of the interventions.

Sources: resident's care plan, interview with RPN #101, #103, and ADOC/Falls Lead.
[704758]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff collaborated with each other in the implementation of the plan of care of a resident's medication.

Rationale and Summary:
A resident exhibited responsive behaviours daily during care. Review of Electronic Medication Records (EMAR) revealed that pro re nata (PRN) medication was not administered to the resident prior to care. PSW #109, #110, #113, and #118 stated that the resident exhibited responsive behaviours during care however, they did not collaborate with the registered staff to administer PRN medication prior to care. RPN #112, #115, and #123 stated they were aware that the resident exhibited responsive behaviours during care, however they did not administered PRN medication.

ADOC/Behavioral Supports Ontario (BSO) acknowledged that PSWs and Registered staff were expected to collaborate with each other to ensure intervention of PRN medication was implemented to deescalate the resident's responsive behaviours during care.

Staff failure to collaborate with each other put the resident at risk of not receiving effective treatment to manage their responsive behaviours.

Sources: resident's clinical records, and interviews with PSW #109, #110, #113, #118, RPN #112, #115, #123 and ADOC/BSO Lead.
[704758]

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Rationale and Summary

A resident had a history of responsive behaviours and exhibited them daily. ADOC/ BSO Lead verified that no strategies and interventions were developed to prevent and manage the resident's responsive behaviours.

Failure to ensure that written strategies were developed to manage the resident #'s physical aggression, placed the resident at risk of reoccurrence and escalation of responsive behaviours.

Sources: resident's clinical records, and interviews with ADOC/ BSO Lead and other staff. [704758]

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that pain medication was administered to a resident in accordance with the directions specified by the prescriber.

Rationale and Summary
A resident was assessed as they were experiencing pain due to an unknown injury. The resident had a PRN order for pain medication. RPN administered a second dose when the first dose was ineffective and acknowledged that they did not follow prescriber's order. ADOC/Pain Lead acknowledged that RPN was expected to administer pain medication to the resident in accordance with the directions for use specified by the prescriber. Clinical Pharmacist stated that it is important for registered staff to administer this pain medication as prescribed to avoid health risk to the resident.

Failure of staff to administer PRN pain medication to the resident as prescribed, put them at risk of developing negative health outcomes.

Sources: resident's EMAR, and interviews with RPN, ADOC/Pain Lead, and other staff. [704758]

WRITTEN NOTIFICATION: General requirements

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and resident response to interventions were documented.

Rationale and Summary
The home submitted a CIS when a resident had an injury of unknown etiology. The resident's records revealed that there was no documentation related to this incident. The home did not complete an investigation related to this incident. PSW stated that during care, they observed a significant change in the resident. They reported this to the RPN immediately. RPN stated that they assessed the resident, however, they did not document their assessment and actions. Furthermore, they stated that a physician was not notified of resident's change in status.

ADOC acknowledged that RPN was expected to document their assessment of the resident's injuries, and interventions.

There was a risk to the resident's health and safety when their assessments, reassessments and response to interventions were not documented, as there were no further actions to monitor the resident and provide appropriate interventions as required.

Sources: resident's clinical records, and interviews with PSW, RPN and ADOC.
[704758]

WRITTEN NOTIFICATION: Pain management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

The licensee has failed to ensure that monitoring of a resident in response to and the effectiveness of the pain management strategies.

Rationale and Summary
A resident was assessed as they were experiencing pain due to an unknown injury. The resident had a PRN order for pain medication which was administer to the resident. RPN stated that they did not go back to the resident to monitor their response and the effectiveness of the pain medication. ADOC/Pain Lead acknowledged that RPN was expected to monitor the resident's response to and the effectiveness of the pain management strategy.

Failure to monitor the response to and the effectiveness of pain medication, put the resident at risk of not receiving further interventions.

Sources: resident's clinical records, and interviews with RPN and ADOC.
[704758]

WRITTEN NOTIFICATION: Pain management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident was assessed as they were experiencing pain due to an unknown injury. The resident had a PRN order for pain medication and RPN administered that medication, however the pain medication was not effective, and the pain was not relieved. RPN stated that they did not complete an electronic pain assessment. ADOC/Pain Lead acknowledged that RPN was expected to complete an electronic pain assessment when pain was not relieved following interventions.

Failure to complete a pain assessment using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial intervention, put them at risk of not receiving further interventions or monitoring.

Sources: resident 's clinical records, and interviews with RPN, and ADOC.
[704758]

WRITTEN NOTIFICATION: Police notification

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of a suspected incident of abuse and neglect to residents #005 #006 and #007 that the licensee

suspected may have constituted a criminal offence.

Rationale and Summary
The MLTC received the following critical incidents in regards to allegations of abuse and neglect:

-CIS #2594-000011-22 was related to an allegation of physical abuse to resident #005
-CIS #2594-000030-22 was related to an allegation of physical abuse to resident #006
-CIS #2594-000015-22 was related to an allegation of neglect to resident #007

The licensee's policy Prevention of Abuse and Neglect of a Resident #VII-G-10.00 stated "Immediately notify the police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence. Notification to the police is required even if a capable resident asks that the police not be called".

ADOC and the ED indicated police was not contacted as resident #005 #006 and #007 did not consent to the police being involved. ADOC and the ED acknowledged the police should have been contacted.

Sources: Licensee's policy Prevention of Abuse and Neglect of a Resident #VII-G-10.00 Last reviewed October 2022, CIS #2594-000011-22, #2594-000030-22, #2594-000015-22, and interviews with ADO and the ED.
[704757]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report for an allegation of abuse.

The licensee's policy to promote zero tolerance of abuse and neglect of residents required any

team member to inform the nurse in charge in the community of any suspected incident of abuse.

PSW stated during an interview that they became aware of the allegation but did not report it to anyone. ADOC verified that the PSW was required to report the allegation to the nurse in charge.

Sources: CIS #2594-000030-22, the licensee's policy Prevention of Abuse and Neglect of a Resident #VII-G-10.00 Last reviewed October 2022 interview with PSW and ADOC.
[704757]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The MLTC received a CIS report related to an allegation of neglect of a resident.

The ED confirmed on an interview that the incident was reported late to the director.

Sources: CIS #2594-000015-22 , interviews with ADOC and the ED.
[704757]

WRITTEN NOTIFICATION: Duty to protect

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff in the home.

Rationale and Summary
The MLTC received a CIS report related to an allegation of neglect of a resident. The resident stated they did not receive required care for several hours.

According to the resident's clinical health records, the resident had altered skin and their care plan stated they staff was required to check them for required care every few hours.

ADOC verified that an investigation was completed by the home, and it concluded that staff neglected the resident.

Failure to provide adequate care and services placed the resident at significant risk for skin breakdown.

Sources: CIS #2594-000015-22, resident's plan of care, investigation notes, and interview with ADOC.
[704757]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary
Observations of the home's IPAC practices identified the home did not follow the manufacturer's instructions for the use of the rapid antigen test (RAT). The instructions on the RAT kit required the user to swab the nasal orifice for a minimum of five seconds. During the observations the staff swabbed the nasal orifices for approximately one second.

The IPAC Lead and screener confirmed that all staff conducting the RAT test were required to follow the manufacturer's instructions in order to effectively screen for COVID-19. There was actual risk of harm to residents, staff and visitors related to not following the RAT device's instructions as they pertain to the accuracy of the test results and consequently potential

spread of an infectious disease.

Sources: IPAC observations, review of the Rapid Response kit manufacturer's instructions by BTNX, interviews with the IPAC Lead and screener.
[704757]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed as it relates to hand hygiene practices.

Rationale and Summary
During observations conducted in the home, staff were observed not doing hand hygiene before and after resident contact, after touching their mask, and after the removal of gloves.

According to the resident's policy "Hand Hygiene, IX-G-10.10", staff were required to wash their hands before and after contact with the resident's environment, and after removing gloves.

The Infection Prevention and Control (IPAC) Lead confirmed staff were required to do hand hygiene before and after resident contact and before and after touching their mask. Not adhering to hand hygiene best practices placed the residents at risk of contracting infectious diseases.

Sources: IPAC observations, Licensee's policy Hand Hygiene, IX-G-10.10 last reviewed on October 2022, and interview with the IPAC Lead.
[704757]