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: April 6, 2023	
Inspection Number: 2023-1215-0003	
Inspection Type: Critical Incident System	
Licensee: St. Clair O'Connor Community Inc.	
Long Term Care Home and City: St. Clair O'Connor Community Nursing Home, East York	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature**
Additional Inspector(s) Elizabeth Cabral (000754) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23-24, 27-28, 2023.

The following intake(s) were inspected:
· Intake: #00018513 - was related to falls prevention and management.
· Intake: #00022859 - was related to resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
On a specified date, a resident had a fall. A Registered Nurse (RN) misinterpreted a Personal Support Worker (PSW) description of the incident and did not believe the resident had fallen.

The home's falls prevention and management policy stated that after a fall, a registered staff should complete an initial physical and neurological assessment and a post-fall huddle. As a result of the misunderstanding between the RN and the PSW, the required post-fall assessments were not completed.

The Director of Care (DOC) indicated that there was concern that the resident was not assessed properly due to the misinterpretation.

Failure to conduct a post-fall assessment after the resident had fallen delayed the process of identifying any serious injuries.

Sources: Interviews with a PSW, a PSW Student, an RN, and the DOC, the home's falls prevention and management policy, CIS Report.

[740849]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to immediately report to the Director when there was reasonable grounds to

suspect improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

Rationale and Summary
On a specified date, the home received a written complaint related to suspected improper or incompetent care of a resident. The CIS report was submitted eight days late.

Failure to immediately report delayed the involvement of the MLTC.

Sources: CIS report, interview with the DOC.

[740849]

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1)

The licensee has failed to comply with pain management processes for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a pain management program that provides monitoring of residents' responses to, and the effectiveness of, the pain management strategies, and must be complied with.

Specifically, staff did not comply with the licensee's Pain Management Program.

Rationale and Summary
A resident was prescribed as needed (PRN) pain medication. The pain medication was administered a number of times within a number of consecutive days when the resident complained of new and worsening pain. Prior to the administration of pain medications, there was no documented pain. No pain assessment was completed within the period that the pain medication was provided to the resident. The physician was not notified within this period either.

The home's pain management policy indicated that a comprehensive pain assessment must be completed with any new pain. The policy also indicated that a physician or nurse practitioner should be notified of any reported sudden onset of new or worsening pain.

An RN and the DOC stated that a pain assessment should have been completed when the resident presented with new pain and the physician should have been notified.

Failure to conduct a pain assessment and notify the physician of a new pain increased the risk of the resident experiencing unmanaged pain for a longer period.

Sources: A resident's clinical records, the home's pain management, interviews with an RN and the DOC.

[740849]

WRITTEN NOTIFICATION: Plan of Care

NC #004 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
A resident was at risk for falls. The resident required a specified intervention when walking in their room to minimize falls.

On a particular day, the specified intervention was not implemented when the resident was walking in their room. The resident had a fall.

A PSW, an RN, and the DOC confirmed that the specified intervention was not implemented prior to the resident's fall.

Failure to implement the specified intervention as per their plan of care increased the risk of falling.

Sources: the resident's clinical records, interviews with a PSW, a PSW Student, an RN, and the DOC.

[740849]

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
A resident was prescribed a specified therapy. There were multiple interventions in place in the resident's plan of care to ensure the therapy was administered effectively.

Within a specified month, the resident's plan of care was not followed when a number of specified interventions were not implemented.

An RN and the DOC indicated that the resident's plan of care should have been followed.

Failure to follow the resident's plan of care increased the risk of not receiving the therapy effectively.

Sources: the resident's clinical records, inspector #740849's observations, interviews with an RN and the DOC.

[740849]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Educate a specified PSW and a specified RN on safe transferring and positioning of a resident post-fall.
2) Document the education from step 1, including the date and staff member who provided the education.
3) Review the home's training material for PSW students, with emphasis on safe transferring and positioning of a resident post-fall.
4) Document the PSW student's training from step 3, including the date and the staff member who provided the training or training material.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
On a specified day, a resident had a fall. A PSW and a PSW Student provided a type of transfer to the resident before they were assessed by a registered staff. The resident was transferred to the hospital

when they sustained further complications. The resident sustained a significant change in their status as a result of the injuries from the fall.

The RN and the DOC indicated that residents should not be moved after a fall and should immediately report to a registered staff. The DOC also indicated that the type of transfer provided from the PSW and the PSW student was inappropriate in this incident. This was consistent with the home’s falls prevention and management policy.

The PSW student and RN were not fully aware of the home’s falls prevention and management policy.

Failure to use safe transferring and positioning techniques when assisting the resident increased the risk of exacerbating their existing injuries.

Sources: Interviews with a PSW, a PSW Student, an RN, and the DOC, the home’s falls prevention and management policy, CIS Report.

[740849]

This order must be complied with by May 19, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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