Ontario

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

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

Toronto District
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Public Report

Report Issue Date: February 25, 2025

Inspection Number: 2025-1595-0001

Inspection Type:
Other
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Carefree Lodge, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 18-21, and 24-25, 2025

The following intake(s) were inspected:

- Intake: #00134616 - CI #M596-000026-24 was related to Fall prevention and management
- Intake: #00135361 - CI #M596-000028-24 was related to Disease outbreak
- Intake: #00137693 - CI #M596-000001-25 was related to Prevention of abuse and neglect
- Intake: #00139202 was related to outstanding Emergency Planning Annual Attestation

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Respect and Dignity

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was spoken to with respect and in a way that fully recognized their inherent dignity.

A PSW asked about the resident's personal care needs loudly in a common area which was undignifying and their language was infantilizing.

Sources: Observation, interview with a PSW.

[000825]

WRITTEN NOTIFICATION: Accessible Communication

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 47
Communication methods
s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

The licensee failed to ensure that the strategies developed to facilitate communication with a resident with language barriers, were implemented.

A resident's care plan included strategies to facilitate communication with the resident. However, a RPN and a PSW did not use those strategies to communicate with the resident when it was required. As a result, the resident became increasingly agitated as their needs were not being met.

The RPN and the PSW both acknowledged risk for miscommunication causing the resident agitation when their care planned intervention for communication were not implemented.

Sources: Observation; the resident's clinical records; interviews with a RPN and a PSW.

[000825]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that the fall prevention and management program was implemented related to the use of a fall prevention equipment for a resident.

The resident had a history of fall and had specific equipment included in their plan of care to reduce the risk of falls or injury. During an observation the fall prevention equipment did not function to alert staff. A RPN confirmed that the fall prevention equipment was not implemented as per the resident's plan of care.

Sources: The resident's clinical records and interview with a RPN.

[741672]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a RPN wore the required personal protective equipment (PPE) when they were providing care to a resident.

A RPN failed to ensure that they wore required PPE in accordance with the IPAC Standard 9.1 that Routine Practices and Additional Precautions are followed in the IPAC program. Specifically, the RPN did not wear required PPE when entering a resident's room, who was on additional precautions, and provided care, which is part of the home's procedure for properly applying PPE.

Sources: An observation, IPAC Standard for long Term Care Homes, revised September 2023, Additional Requirement 9.1, Infection control policy, Home's infection control policy.

[741672]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

The licensee has failed to ensure the infection prevention and control manger designated under subsection (5) carried out their responsibilities in the home in regards to IPAC audits.

Specifically, the IPAC manager failed to ensure that audits were conducted, at a minimum quarterly, of specific activities performed by some of the designated staff in the selection, donning, and doffing of personal protective equipment (PPE), as well as hand hygiene, as required by Additional Requirement 2.1 under the IPAC Standard.

Sources: Review of PPE use and hand hygiene Audit Summary Reports for October - December 2024, and January 2025, IPAC Standard for Long-Term Care Homes, Revised September 2023; and interview with the IPAC manger.

[741672]

WRITTEN NOTIFICATION: Emergency Plans

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure that the emergency planning attestation form was submitted to the Director. The home did not submit the required attestation to the Director as required by the due date.

Sources: Interview with the administrator

[741672]

WRITTEN NOTIFICATION: Emergency Plans

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed by the home, in relation to alcohol-based hand rub (ABHR).

Specifically, ABHR must not be expired as required by 3.1 IPAC Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024. Multiple wall mounted ABHR on a designated residents' home area were observed to be expired.

Sources: Observation and interview with the IPAC Manager.

[741672]