Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection 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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 28, 2016 | 2016_297558_0002 | 028602-16 | Resident Quality Inspection |

## Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

## Long-Term Care Home/Foyer de soins de longue durée

Norfinch Care Community
22 NORFINCH DRIVE NORTH YORK ON M3N 1X1

## Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BARBARA PARISOTTO (558), SHIHANA RUMZI (604)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): September 26, 27, 28, 29, 30, 2016.**

**During the course of the inspection, the inspectors conducted a tour of the home, observed home areas, staff to resident interactions, medication administration, dining and snack observation, reviewed resident health records, staff training records, Residents' Council minutes, and applicable policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Associate Director of Care (ADOC), Director of Dietary Services (DDS), Director of Resident Programs/Residents' Council Assistant, Registered Dietitian, Physiotherapist, registered nurse (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aide (DA), Residents' Council president, Family Council president, residents and family members.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Dignity, Choice and Privacy**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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 :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #003 was triggered from stage one for potential restraint through resident observations.

During the course of the inspection resident #003 was observed sitting in a variety of positions, between meals; in an upright position, at approximately 30 degrees and at approximately 45 degrees.

A review of the physician's order review revealed an order indicating the resident should be seated at an identified degree at identified times of the day.

A review of the most recent written plan of care did not include any direction on when the resident should be seated at the identified degree.

Interviews with PSW #109 and #113 revealed conflicting information. PSW #109 indicated the resident is seated at 45 degrees as determined by the PSW and PSW #113 indicated the resident is seated at 15-30 degrees as informed by the nurses. A review of the Kardex on point of care (POC) by PSW #113 revealed direction pertaining to the degree resident #003 should be seated at was not available.

Interviews with RPN #115 and the PT indicated that the physician's order related to the

degree the resident was to be seated at should be documented in the written plan of care. [s. 6. (1) (c)]

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

Resident #005 was triggered from stage one for no plan - low body mass index (BMI) through staff interview.

A review of the resident written plan of care of an identified date revealed an identified nutritional intervention to be served at lunch.

An observation was conducted by the inspector on an identified date. The inspector observed the fluid cart parked near the servery area in the dining room and the cart consisted of two labelled items for resident #005: 125ml of an identified beverage and the identified nutritional intervention.

A PSW arrived and started to feed resident #005 his/her soup when PSW #105 placed the identified beverage on the table and turned to pick up the identified nutritional intervention and it fell as the lid was in the PSW's hand. The item spilled on the floor and PSW #105 cleaned it up. The PSW was observed going to the servery and informing the DA the item spilled and needed another for resident #005. PSW #105 was then observed to bring an alternate substance in a bowl and placed it in front of resident #005. The inspector observed resident #005’s full lunch meal and observed that the resident did not receive the identified nutritional intervention as per the plan of care.

An interview with RN #100 who fed the resident his/her entree indicated to the inspector the alternate substance was fed to the resident. When asked if the resident had the identified nutritional intervention for lunch the RN confirmed the resident did not.

An interview with PSW #105 confirmed the above observation and indicated he/she informed DA #106 and was told that the nutritional intervention was not available and was given the alternate as a substitute.

An interview with DA #106 confirmed PSW #105 requested the identified nutritional intervention and informed him/her that there wasn't any more available. DA indicated the identified nutritional intervention is portioned down stairs in the kitchen for each meal and sent up and he/she did not have an extra serving and an alternate was given to the PSW.

DA looked at the special diet list binder stored in the servery and indicated resident #005 receives the identified nutritional intervention at lunch and confirmed the resident did not receive the intervention at lunch.

An interview with the Director of Dietary Services (DDS) indicated the identified nutritional intervention is prepared in the kitchen and there is a case of the item available in the main kitchen refrigerator. The DDS indicated DA staff have to come down to the kitchen and are able to get more at any time. The DDS confirmed on the date indicated above the plan of care was not followed for resident #005 and the resident did not receive his/her identified nutritional intervention. [s. 6. (7)]

***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 that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,***
***- to ensure that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On September 26, 2016, at 0935 hrs, during the initial tour of the home, the inspector observed a door labelled E-Housekeeping Room on home area Sunshine Valley. The door opened when pushed and closed without locking. The door was equipped with a pin pad.

RPN #120 was seen to be coming up the hall and the unlocked door was brought to his/her attention by the inspector. The RPN pushed the door, and it opened and closed again without locking.

An observation inside the E-Housekeeping Room revealed the following items:
1) Neutral Floor cleaner- pump consisted of one red button to expel the chemical
2) Purell hand sanitizer - multiple cases stored in the room

An interview with RPN #120 indicated the door is to be locked when not in use and confirmed the door opened and did not lock when the door was closed. The RPN indicated he/she would inform management as it is a risk to residents and that the magnetic strip at the bottom of the door indicating if the room was vacant was preventing the door from closing. [s. 9.]

***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 that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (2) The licensee shall ensure that,**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no resident who requires assistance with eating was served a meal until someone was available to provide the assistance required by the resident.

Resident #003 was triggered from stage one for no plan - low BMI through staff interview.

At 0838hrs on September 28, 2016, during an observation of the breakfast meal the inspector observed a bowl of porridge and fluids placed in front of resident #003. The resident did not attempt to eat or drink independently.

A record review of the resident's most recent Minimum Data Set (MDS) assessment revealed the resident requires total assistance with eating.

At 0922hrs PSW #109 was observed to serve the entree to the resident and proceed to feed the resident the entree. At 0930hrs the porridge was not yet offered to the resident at least 50 minutes after being placed on the table.

An interview with PSW #109 at 1333hrs revealed the resident ate approximately 75 per cent of breakfast, including toast, egg, cheese and porridge. The inspector confirmed with the PSW that the porridge was offered to the resident, and the PSW indicated the resident consumed about half the bowl. The PSW further indicated it is not customary for the resident to be served a meal, in this case the porridge, until someone is available to provide the assistance, and that this morning the recreation staff who often are present to assist, were not.

The PSW confirmed the process would be to obtain the porridge from the servery at such time someone was available to assist the resident with the meal. [s. 73. (2) (b)]

***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 that no resident who requires assistance with eating was served a meal until someone was available to provide the assistance required by the resident, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**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 individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure to fully respect and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Observations were conducted on September 28, 2016, at 0830hrs, on an identified home area. The inspector observed resident #007 sitting at an identified dining table and was drooling out a large amount of substance on to his/her clothing protector. PSW #101 was observed going up to the resident's table and putting the thick substance back into the resident's mouth utilizing a spoon and then walked away. The inspector observed the substance drool out of the resident's mouth again.

PSW #103 was observed to arrive at resident #007's table and cleaned resident #007's mouth, change resident's clothing protector and placed two new protectors on the resident's lap. The PSW was then observed to informed the RPN who was outside the dining room with his/her medication cart. The inspector approached PSW #103 and inquired as to what the substance was coming out of resident's mouth, the PSW indicated it appeared to be medication.

The interview with PSW #101 confirmed he/she was attempting to push medication which was drooling out from the resident's mouth back in to his/her mouth as he/she was the resident's primary PSW. When asked what the substance was the PSW indicated it was the resident's medication. When asked when the medication was given PSW indicated RPN #102 gave the resident the medication in the hall not too long before coming in the dining room. The PSW indicated he/she knows it was medication and did it as he/she was the resident's primary PSW but would not do it to a resident he/she did not know. The PSW indicated it was not right of him/her to do that.

An interview with PSW #103 confirmed the above observation and indicated it was not right to spoon something back into resident #007's mouth as you don't know what it was. The PSW also stated it was the home's expectation resident's be respected and treated with dignity and this was not respecting the resident's dignity.

An interview with RPN #102 indicated he/she did administer crushed medications mixed with three spoons of applesauce to resident #007 and observed the resident swallow the medication. The RPN further indicated PSW #103 came to him/her and showed him/her the clothing protector and indicated it was not all medication. The RPN further stated

scooping  a substance drooling out of resident #007's mouth without knowing what the substance was not right and should have called him/her to assess it.

An interview with the ADOC stated, after the above incident was described, that it should not have happened and should have been reported to the nurse. The ADOC further stated the PSW should not be scooping anything back into the resident's mouth and the resident's right to be respected with dignity was not followed. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On September 26, 2016, at 0915hrs, on an identified home area the inspector observed a medication cart to be parked outside the dining room.  The E-MAR screen was open to resident #001 revealing the resident's personal medication administration record which was visible to the public.

An interview with RPN #102 indicated he/she was in the dining room and confirmed the E-MAR screen was open to resident #001's medication profile and indicated it is to be locked when not in use. The RPN further stated when the screen is unlocked information is visible to the public and did not protect the above mentioned resident's personal health information. [s. 3. (1) 11. iv.]

---

**WN #5:  The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD has been approved by:
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

Resident #004 was triggered from stage one for potential restraint and potential side rail

restraint through resident observation.

Documentation review of the plan of care dated September 16, 2016, indicated the following:
- an identified Personal Assistance Service Device (PASD)
- Intervention: Resident #004 will remain free of complications related to the PASD. The PASD is used to offload pressure.

A review of resident #004's MDS quarterly review assessment dated June 2,2016, and annual assessment dated September 2, 2016, indicated the following:

Resident #004 needed extensive assistance for bed mobility, transfers, with the use of bed rails. The resident was identified as not having any functional limitations in range of motion (ROM) and utilized a wheel chair for mobility wheeled by others.

The MDS assessment also indicated that two side rails were used daily.

Observation conducted on September 27, 28, and 29, 2016, at various times of the day revealed resident was utilizing the identified PASD and bilateral quarter bed rails when in bed.

Interviews with PSW #111 and #118 confirmed resident #004 utilized the identified PASD and bilateral quarter bed rails for Activities of Daily Living (ADL) each day.

An interview with Registered Practical Nurse (RPN) #102 confirmed resident #004 utilized the identified PASD and bilateral quarter bed rails for ADLs each day. RPN #102 indicated the home's policy prior to using a Personal Assistance Service Device (PASD) is to obtain an order from the physician, nurse, or Physiotherapist (PT).

A review of resident #004's health record did not contain an order by a physician, RN, RPN, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations. This was confirmed by RPN #102.

The home's policy "Personal Assistance Service Devices (PASD)", policy number: VII-E-10.10 with a current revision date of November 2015, directed staff under procedure that all registered staff will:
1) Obtain approval from one of the following:

•Physician
•Registered nurse
•Registered practical nurse
•Member of the College of Occupational Therapists of Ontario
•Member of the College of Physiotherapists of Ontario, or
•Any other person provided for in the regulations 79/10

An interview conducted with the Associate Director of Care (ADOC) confirmed the home's policy was to obtain on order before the use of a PASD and that there was no order in resident #004's chart. [s. 33. (4) 3.]

2. The licensee had failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in the resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #004 was triggered from stage one for potential restraint and potential side rail restraint through resident observation.

Documentation review of the plan of care dated September 16, 2016, indicated the following:
- an identified Personal Assistance Service Device (PASD)
-Intervention: Resident #004 will remain free of complications related to the PASD. PASD to offload pressure.

A review of resident #004's MDS quarterly review assessment dated June 2,2016, and annual assessment dated September 2, 2016, indicated the following:

Resident #004 needed extensive assistance for bed mobility, transfers, with the use of bed rails. The resident was identified as not having any functional limitations in range of motion (ROM) and utilized a wheel chair for mobility wheeled by others.

The MDS assessment also indicated that two side rails were used daily.

Observation conducted on September 27, 28, and 29, 2016, at various times of the day revealed resident was utilizing the identified PASD and bilateral quarter bed rails when in bed.

Interview with PSW's #111 and #118 confirmed resident #004 utilized the identified PASD and bilateral quarter bed rails for Activities of Daily Living (ADL) each day.

An interview with resident #004's Substitute Decision Maker (SDM) indicated he/she did not remember giving consent for the use of the identified PASD or the use of the bilateral quarter bed rails as PASD but does know his/her mother uses both devices on a daily basis and has no concerns with his/her mother using them.

An interview with Registered Practical Nurse (RPN) #102 confirmed resident #004 utilized the identified PASD and bilateral quarter bed rails for ADLs each day. RPN #102 indicated prior to using a PASD family consent was needed.

A review of resident #004's health record did not contain a consent from the SDM for the use of the identified PASD or bilateral quarter bed rails which where identified as PASD for the resident. This was confirmed by RPN #102.

An interview conducted with the ADOC confirmed a consent was to be obtained before the use of a PASD and that there was no consent found in resident #004's chart. [s. 33. (4) 4.]

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On September 28, 2016, on an identified home area the inspector conducted a narcotic storage observation. The inspector observed the narcotic lock box to consist of the following items along with stored narcotics:
-A cell phone cord
-Three zip lock bags with earrings
-A zip lock bag with a ring
-Two watches
-A zip lock bag with TTC tickets.

An interview with Registered Nurse (RN) #100 confirmed the items found in the locked narcotic bin and indicated there was no other place he/she was aware of to store the items. The items were removed from the narcotic bin and the Director of Care (DOC) arrived, indicating an alternate location will be found for the items. [s. 129. (1) (a)]

**Issued on this 2nd day of December, 2016**

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

**Original report signed by the inspector.**