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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 15, 2017	2017_378116_0009	010288-17	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

SARAN DANIEL-DODD (116), CHAD CAMPS (609)

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): June 5, 6, 7, 8, 9, 2017.

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

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Director of Dietary Services (DDS), Registered Dietitian, registered nurse (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides (DA), Residents' Council president, Family Council president, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
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.
- **5 WN(s)**
- **2 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	Legendé 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

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

On an identified date, inspector #609 observed an identified room's door unlocked, open and unattended. Inside, contained identified medical supplies.

During an interview with RPN #104, they verified that the identified room door should have been closed and locked when not in use.

During an interview with the Executive Director (E.D.), they failed to produce any policy or procedure related to the home's process to ensure that non-residential areas are kept closed and locked.

During another interview with the E.D., they verified that the identified room should have been closed and locked when not in use. [s. 9. (1) 2.]

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 equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On an identified date, on an identified unit, inspector #116 observed a medication cart stored in a hallway unlocked and unattended. The inspector was able to access the contents inside and noted several pre-poured medications crushed in an identified substance.

At an established time, registered staff #111 who was assigned to the cart was observed exiting an identified area and returned to the medication cart. An interview held with RN staff #111 indicated that he/she went to attend to a resident and the medications were prepared for the upcoming medication pass. RN staff #111 further confirmed being aware that the medication cart is to be locked at all times when unsupervised.

On a subsequent date, on the same identified unit, a medication cart was noted to be stored in the hallway unlocked and unattended. The inspector was able to gain access to the contents inside and observed a medication cup containing a pill and a crushed substance. The letters d/c were inscribed on the medication cup. Registered staff #106, who was assigned to the cart returned at an established time and identified which residents the medications belonged to. Interviews held with registered staff #106, the E.D. and the DOC confirmed that the medication cart is to be locked at all times when not attended to. [s. 130. 1.]

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 areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #3: 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:
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 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 an identified date, on an identified unit, a medication cart was observed to be stored in a hallway unlocked and unattended.

The E-MAR screen was open and displayed the personal health information for resident #015. The health information was visible to the public.
An interview with registered staff #111 indicated he/she was attending to a resident and the E-MAR screen was active displaying identified personal health information for resident #015 and it should be locked when not attended to. Further interviews held with RN #111, the E.D. and the DOC confirmed that the E-MAR screen is to be locked at all times when not in use to protect resident's personal health information. [s. 3. (1) 11. iv.]

WN #4: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the personal assistance services device (PASD) described in subsection (1) that is used to assist a resident with a routine activity of living included in the residents' plan of care.

Resident #002 was triggered from stage one for an identified device through resident observation.

Observations conducted during stage one of the resident quality inspection (RQI) and on identified dates, revealed an identified device attached and engaged to an identified article for resident #002.

Interviews with PSW staff #106 and registered staff #'s 106 and 107 indicated that resident #002 requires the use of the identified device as a PASD.

A review of the current written plan of care revealed that the use of the PASD is not included within the written plan of care. [s. 33. (3)]

2. Resident #003 was triggered from stage one for potential identified device(s) through resident observation.

Review of the written plan of care for an identified date, indicated the resident required the use of identified devices.

During stage one of the RQI and on a subsequent date, identified devices were observed to be in use with resident #003.

Interviews with PSW staff #109, #110 and registered staff #'s 106 and 107 indicated that resident #003 requires the use of the identified devices as a PASD.

A review of the current written plan of care revealed that the use of one of the identified devices was included however, the other identified device for purpose of a PASD was not included within the written plan of care.

Review of an identified audit documents the required use of the identified devices with resident #001 and resident #003.

An interview held with the DOC confirmed that if the identified device(s) are deemed as a PASD for residents #002 and #001 it should be included within the written plan of care. [s. 33. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On an identified date, during the initial tour of the home, inspector #609 observed identified areas to contain used, unlabelled personal care items.

On a subsequent date, observations of the identified areas again found used, unlabelled personal care items.

During an interview with RPN #104, they verified that the used personal care items should have been labelled.

A review of the home's policy titled "Clothing Care and Personal Effects- #VII-C-10.10" last revised in January 2015 indicated that all personal items that were kept in a resident's room must be labelled with the resident's name.

During an interview with the DOC, they verified that all residents' personal items were to be labelled with the resident's name. [s. 37. (1) (a)]

Issued on this 10th day of July, 2017

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

Original report signed by the inspector.