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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2018	2018_646618_0009	007031-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

CECILIA FULTON (618), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 2018.

During the course of this inspection the following complaint log was inspected 006990-18, related to plan of care and wound care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physiotherapist (PT), Nurse Manager (NM), Director of Resident Programs, Resident program staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in the plan of care was provided to the resident as specified in the plan.

During stage one of the RQI the continence care and bowel management triggered related incontinence, for resident #001.

Record review of resident #001's written care plan identified the resident's continence status and identified the interventions in place for resident #001. Interview with personal support worker (PSW) #116 revealed what interventions they were implementing for the resident during the day shift.

Interviews with PSWs #118, 122, and registered practical nurse (RPN) #117 indicated what interventions they used for the resident's continence management, which were different to what PSW #116 had revealed.

The DOC confirmed that resident #001's continence management interventions were those identified by PSWs #118, 122 and RPN #117 and not those identified by PSW #116. The DOC confirmed that staff are expected to follow residents' plan of care, and PSW #116 had not been following the resident's plan of care related to continence care and bowel management.

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.

This inspection was initiated to inspect a concern raised in complaint intake #006990-18, regarding staff not following the resident #016's plan of care.

Record review revealed that resident #016 transfer requirements.

On an identified date in February 2018, resident #016 was discovered to have an identified injury. The injury was first identified by PSW #119 when they were in the shower room with the resident. PSW #119 revealed how they had transferred the resident, which was not what is identified in the residents written plan of care. PSW #119 was not able to identify when or how this injury occurred, however they did reveal that they had not reviewed resident #016's plan of care and was not aware of their transfer requirements.

The home' investigation of this incident, and interview with the Executive Director confirmed that PSW #119 had not followed resident #016's plan of care.

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 the care set out in the plan,, to be implemented voluntarily.

WN #2: 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. An interview with resident #007 during stage one of the Resident Quality Inspection revealed that they had an incident with staff that made them feel they had not been treated with respect and dignity.

Resident #007 revealed that on an occasion which they recalled was several months ago, they were being weighed by three PSWs and the PSWs made negative comments about the residents' size and eating habits. Resident #007 revealed that they had reported this to the nursing station, but they were unable to recall any of the names of the staff involved or to whom they reported it. The resident further revealed that they had informed one of their family members about this incident. Resident #007 revealed that this incident made them very upset and made them feel ashamed.

Interview with the resident's family member revealed that they had received a call from the resident in which the resident told them about this encounter and stated that the staff had made negative comments regarding the resident's eating habits. Resident #007's family member recall that the resident was quite upset recounting this incident. Resident #007's family member did not know any of the names of the staff involved and had not reported this incident to anyone.

Interview with RPN #120 revealed that they were the person to whom the resident made the initial report. RPN #120 recalled the incident occurred in February 2018. RPN #120 was unable to recall resident #007's demeanor at the time of reporting. RPN #120 revealed that when the resident told them this, they sought out PSW #121 to discuss this with, as this PSW was one of the persons who had weighed the resident. According to RPN #120, PSW #121 denied knowledge of the allegation and the two staff returned to resident #007's room to gather more information. When they returned to the resident to ask about this and seek out further information, resident #007 denied the incident or having reported the incident to RPN #120.

RPN #120 revealed that they didn't know what to make of things at that point, and that they did nothing further, did not document it or report it to anyone else. RPN #120 revealed that they are aware that any alleged or suspected abuse is to be reported to the manager and that the resident's contradictory stories caused confusion about what should be done.

Interview with the ED revealed that a statement of this nature is unacceptable.

2. The licensee has failed to ensure that a resident's right to give or refuse consent to any treatment, care or services for which consent is required by law is fully respected.

This inspection was initiated to inspect an issue of resident rights identified in stage one of the inspection. In response to a question about whether the resident is able to make decisions about the care they receive, the resident replied no, stating that a while ago they were sent to the hospital and that they didn't want to go, they did not feel that it was necessary, but the staff insisted and called the top person who argued with the resident and so eventually the resident gave in and went to the hospital.

Interview with resident #003 revealed that on an identified date in 2018, the resident was informed by staff that the physician had ordered that the resident go to the hospital due

to findings identified on a diagnostic test.

Resident #003 revealed to the RPN that they felt fine, and informed RPN #115 that they didn't want to go at that time, and that they would follow up and go to the hospital in a few days when their friend will be available to accompany them.

Record review revealed that resident #003 is their own Power of Attorney (POA), and that their advanced directives are Level 1 indicating end of life care in the Long Term Care facility. No transfer to hospital, no CPR.

Review of a physician pertaining to this issue, identified that the resident is their own POA and that if they agree to send them to the hospital.

Interview with RPN #115 revealed that they were the staff who received the physician order. RPN #115 further revealed that the resident was not exhibiting any symptoms and that the resident's initial response to being sent to the hospital was they they didn't want to go and said they would go in a few days. RPN #115 revealed that they explained the risks of not going to the hospital to the resident and that the resident understood the risk of declining the hospital transfer. RPN #115 revealed that they informed their Nurse Manager (NM) #111 about the issue.

Interview with NM #111 revealed that when they met with the resident, the resident again declined to be transferred to the hospital, stating that they would wait to go with their friend, but that eventually the resident agreed to go. NM #111 revealed that the resident understood the risks with their decision to decline hospital transfer.

Interview with resident #003 revealed that they understood the risks of not going to the hospital, but that the staff insisted they had to go, they called a friend of resident #003 who rushed over and was very upset. Resident #003 described the situation as making them very angry because they would listen to what they wanted.

Issued on this 14th day of June, 2018

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

Original report signed by the inspector.