Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 22, 2019	2019_759502_0016	008682-18, 032163-18, 003759-19, 005582-19	Critical Incident System

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

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 20, 21, 24, 25, 26, July 3, 4 and 5, 2019. Off site July 9 and 17, 2019.

The following intakes were completed in this Critical Incident System Inspection:
- log # 005582-19, (CIS # 2918-000006-19), related to fall,
- log 008682-18, (CIS # 2918-000004-18), related to responsive behaviour,
- log 032163-18 (CIS # 2918-000015-18), 003759-19 and (CIS # 2918-000005-19) related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Resident Relation Coordinator (RRC), and the residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident health records, staffing schedules, staff file, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **2 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was free from neglect by PSW #100.

Critical Incident System (CIS) was submitted to the Director related to an allegation of neglect. A review of the CIS report indicated that Personal Support Worker (PSW) #100 did not provide support to resident #001 after they fell and was lying face down on the floor.

Review of the progress notes indicated that on an identified dated resident #001 had a fall with injury, they were alert and responsive but crying and agitated.
Review of the home's camera footage indicated that resident #001 recorded on the day of the incident indicated that PSWs #100 came out from the room adjacent to the location of the fall incident, observed resident #001 lying face down on the floor, stepped over the resident, who was lying face down on the floor, and went into an identified care area. PSW #100 came out of the identified care area, called for assistance, and then walked away leaving the resident lying face down on the floor.

A review of the home's investigation indicated that PSW #100's employment with the home was terminated because of neglect of resident #001 as the PSW stepped over the resident, who had fallen, and failed to immediately solicit medical assistance.

As PSW #100 was not available for interview, the interviews included in the home's investigation were reviewed. In the home's interviews PSW # 100 stated that they were shocked and did not remember what to do. The PSW also stated that they did not know why they stepped over the resident and ran to the identified care area.

In a joint interview, Director of Care (DOC) #101 and Resident Relation Coordinator (RRC) #102 acknowledged that PSW #100 neglected resident #001 as they did not assist the resident when they had a fall with injury and they were lying face down. They confirmed that the PSW's employment was terminated due to neglect of resident #001. [s. 19. (1)]

2. The licensee has failed to ensure that residents #010, #011, #012, #013, #014 and #015 were protected from abuse by resident #005.

A CIS was submitted to the Director related to abuse.

Review of the CIS report and progress notes indicated on an identified date, resident

#005 exhibited a specified behaviour toward resident #006. Resident #006 fell face down resulting in an injury. Resident #005 and #006 were referred to a specialized service.

Review of resident #005's Minimum Data Set (MDS) assessment completed on an identified date indicated that the resident was cognitive impaired . MDS assessment also indicated that resident #005 had an identified responsive behavior. Resident #005 ambulated independently on the unit.

The written plan of care for resident #005 indicated that they had an identified responsive behaviour and were to be monitored by the staff. Further to this, the resident was assessed by a specialized team and made five recommendations during an identified period, that included specialized drugs therapy, maintaining the interventions of separating resident #005 from co-residents when they display or attempt with the identified behaviour. To maintain a consistent approach of informing them about ramifications of such behaviours.

- On an identified date the specialized team documented that resident #005 continues to have the unexpected intermittent frequent episodes of identified responsive behaviour toward co-residents some of whom are vulnerable and unable to respond to resident #005's acts. Since resident #005 can understand their acts compared to co-residents it becomes ethically inappropriate behaviour and could be considered as the above identified behaviour.

- On an identified date the first dose of the identified drug was administered.
Review of resident #005's Electronic Medical Administration Record (eMar) for an identified period did not include all the above drugs therapy recommended by the specialized team.

According to the progress note with a specified date, resident #005's Substitute Decision Maker (SDM) told the home that they were not surprised as resident #005's has a history of the above identified behaviour.

Review of resident #005's progress notes indicated an identified responsive behavior toward co-residents. Further review of resident #005's progress notes for an identified period indicated the following:

A) Five incidents of the above identified responsive behaviour toward resident #010.

Review of resident #010's current MDS, indicated that the resident was severely cognitive impaired. Resident #010 ambulated independently with a walker on the unit.

B) Five incidents of the above identified responsive behaviour toward resident toward resident #014.

Review of resident #014's current MDS assessment, indicated that the resident was severely cognitive impaired. Resident #014 ambulated independently with a walker on the unit.

C) One incident of the above identified responsive behaviour toward resident toward resident #015.

Review of resident #015's current MDS assessment, indicated that the resident was severely cognitive impaired. Resident #015 required wheelchair with one staff assistance for locomotion.

D) Two incidents of the above identified responsive behaviour toward resident toward resident #013

Review of the resident's current written plan of care indicated that resident #013 was extensively confused due to specified medical condition, and had difficulty communicating with staff daily as they cannot comprehend or express themselves daily.

E) One incident of the above identified responsive behaviour toward resident toward resident #011

Review of resident #011's current MDS assessment indicated that the resident was severely cognitive impaired. Resident #011 required wheelchair with one staff assistance for locomotion.

F) One incident of the above identified responsive behaviour toward resident toward resident #012

Review of resident #012's current MDS assessment, indicated that the resident had a specified medical condition, was moderately cognitive impaired. Resident #012 required wheelchair with one staff assistance for locomotion.

Review of health record for residents #010, #011, #012, #013, #014 and #015 indicated that they were not assessed for their ability to provide consent for the above identified behaviour after each identified incident. Review of resident #005 care plan did not identify any interventions specific preventing the above identified behaviour toward the above-mentioned residents.

In an interview, RN #116 stated that resident #005 exhibited inappropriate behaviors including making inappropriate comments to staff. RN #116 indicated that after the alleged abuse involving resident #013 on an identified date, both residents were separated and closely monitored. Resident #005 was redirected, educated and was being watched not to stay close to co-residents. RN #116 indicated that resident #011 and #013 were wheelchair bound, so they were placed near the nursing station for staff to keep an eye on them.

After reviewing the residents' written plan of care, RN #116 stated that there were no specific interventions in place to protect residents #010 and #012 from the abuse by resident #005 as they ambulate independently with a walker. RN #116 acknowledged that staff monitor them and do not let them sit near resident #005, but it was not possible all the time.

In an interview, RPN #115 indicated that resident #005 exhibited inappropriate behavior toward co-residents and staff. Resident #005 rarely exhibited another identified behaviour. RPN #115 indicated that there was no specific intervention in place, but when the incident occurred, staff move the co-resident away from resident #005 and that environment, place them by the nursing station and closely monitor them. The RPN indicated that the plan was to initiate Dementia Observation System (DOS) to monitor resident #005 and to refer the resident to the Geriatric Mental Health Outreach Team (GMHOT) and Leap of Faith Together (LOFT) team. RPN #115 indicated that resident #005 liked to sit with residents #010 and #012, and sometimes held hands with both residents but sometimes while having conversations resident #005 would exhibit the behaviour mentioned above.

In a joint phone interview, the ED and DOC indicated that the initial referral to GMHOT for resident #005's inappropriate behaviour is on an identified dated in 2019, and the resident is being assessed monthly by the GMHOT team. They indicated that the GMHOT team had discussed the resident's inappropriate behaviour while assessing the resident for the other responsive behaviour. The recommendations were made but the family did not consent for several weeks after the recommendations. The DOC indicated

that on an identified date GMHOT recommended a specified medication, but the home's physician did not carry out the recommendation. The DOC and ED also stated that resident #005's SDM refused to consent to any treatment until June 20, 2019. The resident had scheduled specified medication daily. The ED indicated that all the residents involved in the incident mentioned above, did not have an assessment to consent to specified activities.

Through record review and the interviews, resident #005 was abusing vulnerable residents who were moderately and severely cognitively impaired for eight months period. While all staff interviewed understood that resident #005's behavior constituted a specified abuse of the six vulnerable residents, and in fact had reported their concerns to the management of the home, there were minimal interventions in place to mitigate the risk. The management team stated that they were aware of the alleged incidents of abuse mentioned above. They stated that the current residents' written plan of care did not identify interventions to address the risk and prevent re-occurrence. As a result, the inspector concluded that the home had not taken appropriate steps to protect resident #010, #011, #012, #013, #014 and #015. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

During the inspection related to resident #005's responsive behaviours, the inspector

identified in the resident's progress notes, multiple incidents of abuse toward residents #010, #011, #012, #013, #14 and #15.

The staff of the home did not comply with the following sections of the licensee's Prevention of Abuse and Neglect of a Resident policy, VII-G-10.00, revised on April 2019:
-All team members (employees, volunteers, agency staff private duty caregivers, contracted service providers), resident and families are required to immediately report any suspected or known incidents of abuse or neglect to the provincial health authorities.
-Inform the Power of Attorney for care or the SDM immediately (if the resident is not capable) of the alleged abuse if the incident has caused harm, pain, or distress to the resident.
-The Executive Director or designate initiates the investigation.

Review of the progress notes of resident #005 indicated the following incidents of identified behaviour toward six residents for an identified period as follows:
- five incidents of the above identified responsive behaviour toward resident #010.
- One incident of the above identified responsive behaviour toward resident toward resident #015.
- Two incidents of the above identified responsive behaviour toward resident toward resident #013.
- One incident of the above identified responsive behaviour toward resident toward resident #011.
- One incident of the above identified responsive behaviour toward resident toward resident #012.

Review of residents #010, #011, #012, #013, #14 and #15's progress notes indicated that the residents' SDM were not notified about the incidents related to the identified responsive behaviour mentioned above, except one incident. Further review of the home's records did not identify the home's investigation notes for the above-mentioned incidents.

A review of the progress and the CIS report indicated that the home had not reported to the Director under the LTCH Act 2007, and not investigated the incidents mentioned above.

Interview with the RPN #115 and nurse manager (NM) #116 indicated that resident #005 exhibited the identified responsive behaviour toward residents #010, #011, #012, #013, #14 and #15. NM #116 indicated that the above-mentioned incidents were documented

on the progress notes, but they were not investigated, the Director under the LTCHA, 2007, was not informed and the residents' SDM were not notified.

In a joint interview, DOC and ED confirmed that resident #005 exhibited the identified responsive behaviour toward to residents #010, #011, #012, #013, #14 and #15. Both the DOC and ED acknowledged that the home's Prevention of Abuse and Neglect of a Resident policy was not complied with as they did not notify the residents' SDM, report the alleged incident of abuse to the Director under the LTCHA 2007, and did not investigate them immediately.

Through record review and the interviews, resident #005 was exhibiting the identified behaviour toward vulnerable resident who were moderately and severely cognitively impaired for an identified period. All staff that were interviewed understood that resident #005's behavior constituted a specific abuse of the six vulnerable residents, and in fact had reported their concerns to the management of the home. The home did not notify the residents' SDM, report the alleged incidents of abuse to the Director under the LTCHA 2007, and did not investigate them immediately. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

A CIS was submitted to the Director related to a fall with injury.

A review of the CIS report indicated that on an identified date, resident #002 had am unwitnessed fall with injury and was transferred for treatment.
A review of resident #003's MDS assessment indicated the resident was moderately impaired. They were total dependence on wheelchair with one-person assistance for locomotion on unit.

A review of resident #002's written plan of care under fall risk focus indicated that the resident's biggest risk of falling was when they are left alone, unsupervised and then they try to reposition themselves or try to get up due to poor decision making. In the written plan of care in effect at the time of incident, there was no specific strategy identified to reduce the resident risk of fall when left alone and unsupervised.

A revised written plan of care was completed after resident #002's fall incident mentioned above and did not identify a specific strategy to reduce the risk of fall when left alone and unsupervised.

In an interview, RPN #105 stated that they heard a loud noise followed by the resident screaming in pain. The RPN checked on the resident and found them on the floor with their face down. During the assessment the resident indicated that they were trying to get out of their chair. The RPN stated that the resident was left unattended as they were at their medication card administrating medication and the PSWs were taking care of other residents.

In separate interview, PSW #104, RPN #106 and RN #103 did not identify specific strategies in the plan of care to address resident #002's risk of fall.

In an interview, DOC #101 acknowledged that the intervention outlined in the plan of care did not consider different approaches to reduce resident #002's risk of fall when they are left alone and unsupervised. [s. 6. (11) (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 if the resident was being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any policy in place, the policy was complied with. In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) policy (#VIIG-30.20, revised December 2018), which was part of the licensee's Falls Prevention and Management program that required staff to conduct head injury routines for unwitnessed falls.

A review of the home's policy titled Falls Prevention and Management #VII-G-30.10, under Head Injury Routine policy #VII-G-30.20, revised December 2018, indicated that

post falls assessment requires registered staff to monitor HIR as per the schedule on the form post fall for signs of neurological change including facial drop, behaviour changes, weakness on one side. The HIR routine identified on the form for an unwitnessed fall is every 15 minutes (Q15M) for one hour, every 30 minutes (Q30M) for two hours, every hour (Q1H) for three hours, every two hours (Q2H) for eight hours, and every four hours (Q4H) for twelve hours.

A review of resident #003's MDS assessment completed on an identified date, indicated the resident was moderately impaired. They were total dependence on wheelchair with one-person assistance for locomotion on unit.

A review of the progress notes indicated on an identified date, RPN #105 heard a loud noise followed by the resident screaming in pain. The RPN checked on the resident and found them on the floor with their face down. The resident complained of severe pain, was transferred to the hospital and returned to the home the same day.

A review of the HIR records for resident #002 indicated that there was no head injury routine completed for the fall on an identified date.

In interview with RPN #106 they stated that the home's protocol when a resident has an unwitnessed fall is to assess the resident and initiate the HIR for 72 hours. The RPN was not able to provide any documentation for completed HIR.

An interview, DOC #101 stated that staff were expected to complete the HIR at the appointed times for resident #002's fall incident mentioned above, and they acknowledged that the staff did not. [s. 8. (1) (a),s. 8. (1) (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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any policy in place, the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A CIS report was submitted to the Director related to resident to resident abuse allegation.

Review of the CIS report and the progress notes indicated that an identified date resident #003 exhibited an identified behaviour toward resident #004, who was in specialized care, was calling out for help. The CIS report required the home to amend the report and include:
- resident #003 updated status related to the incident,
- the history of responsive behavior for resident #004,
- Previous responsive behavior strategies set in place for resident - #004, and - the result of investigation

Further review of the CIS report did not identify an amendment that included the above requested information and the outcome of the home's investigation.

In an interview, DOC #106 stated that the investigation was completed, and the allegation of abuse was not founded as the resident did not sustain an injury. The DOC acknowledged that the CIS report was not amended as requested above. [s. 23. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that neglect of a resident by a PSW that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

A CIS was submitted to the Director related to an allegation of neglect.

A review of the CIS report indicated that on an identified date resident #001 attempted to stand up and fell onto the floor. PSW #100 was taking their break in the room adjacent to where the resident was placed. They came out of the room at the time of incident and saw resident on the floor. They stepped over the resident and went to dining room. They came out, shouted for help and walked away rather than providing emotional support to resident in an emergency.

Review of the complaint record completed by the Executive Director (ED) on an identified dated indicated that the resident's Substitute Decision Maker (SDM) raised concerns related to the resident's fall. One day after, the ED documented that they were upset with the conduct of the PSW which can be clarified as neglect.

In a joint interview, DOC #101 and RRC #102 acknowledged that the home suspected neglect of resident #001 by PSW #100 one day after the incident, and the alleged neglect was reported to the Director two days after having reasonable grounds to suspect that neglect of the resident.
[s. 24. (1)]

Issued on this 23rd day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2019_759502_0016
Log No. / No de registre :	008682-18, 032163-18, 003759-19, 005582-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 22, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Norfinch Care Community 22 Norfinch Drive, NORTH YORK, ON, M3N-1X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gajany Sivalingam

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will protect the residents from abuse and neglect.

The compliance plan shall include but is not limited to the following elements:

1. Ensuring all staff are responsive and know what to do when a resident has a fall.

2. A process to ensure timely care is provided to resident #005 and other residents who exhibit specified behaviours, and who are at risk of abusing residents #010, #011, #012, #013, #014 and #015 and any other resident.

3. Ensuring a proactive approach to resident #005's abusive behavior before any other residents are abused.

4. Develop or utilize existing assessment tool to assess residents' ability to consent to certain activities.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector: Julienne Ngo Nloga by Monday August 5, 2019 via email to: TorontoSAO.moh@ontario.ca

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was free from neglect by PSW #100.

Critical Incident System (CIS) was submitted to the Director related to an allegation of neglect. A review of the CIS report indicated that Personal Support Worker (PSW) #100 did not provide support to resident #001 after they fell and was lying face down on the floor.

Review of the progress notes indicated that on an identified dated resident #001 had a fall with injury, they were alert and responsive but crying and agitated. Review of the home's camera footage indicated that resident #001 recorded on the day of the incident indicated that PSWs #100 came out from the room adjacent to the location of the fall incident, observed resident #001 lying face down on the floor, stepped over the resident, who was lying face down on the floor, and went into an identified care area. PSW #100 came out of the identified care area, called for assistance, and then walked away leaving the resident lying face down on the floor.

A review of the home's investigation indicated that PSW #100's employment with the home was terminated because of neglect of resident #001 as the PSW stepped over the resident, who had fallen, and failed to immediately solicit medical assistance.

As PSW #100 was not available for interview, the interviews included in the home's investigation were reviewed. In the home's interviews PSW # 100 stated that they were shocked and did not remember what to do. The PSW also stated that they did not know why they stepped over the resident and ran to the identified care area.

In a joint interview, Director of Care (DOC) #101 and Resident Relation Coordinator (RRC) #102 acknowledged that PSW #100 neglected resident #001 as they did not assist the resident when they had a fall with injury and they were lying face down. They confirmed that the PSW's employment was terminated due to neglect of resident #001. (502)

2. The licensee has failed to ensure that residents #010, #011, #012, #013,

#014 and #015 were protected from abuse by resident #005.

A CIS was submitted to the Director related to abuse.

Review of the CIS report and progress notes indicated on an identified date, resident #005 exhibited a specified behaviour toward resident #006. Resident #006 fell face down resulting in an injury. Resident #005 and #006 were referred to a specialized service.

Review of resident #005's Minimum Data Set (MDS) assessment completed on an identified date indicated that the resident was cognitive impaired . MDS assessment also indicated that resident #005 had an identified responsive behavior. Resident #005 ambulated independently on the unit.

The written plan of care for resident #005 indicated that they had an identified responsive behaviour and were to be monitored by the staff. Further to this, the resident was assessed by a specialized team and made five recommendations during an identified period, that included specialized drugs therapy, maintaining the interventions of separating resident #005 from co-residents when they display or attempt with the identified behaviour. To maintain a consistent approach of informing them about ramifications of such behaviours.

- On an identified date the specialized team documented that resident #005 continues to have the unexpected intermittent frequent episodes of identified responsive behaviour toward co-residents some of whom are vulnerable and unable to respond to resident #005's acts. Since resident #005 can understand their acts compared to co-residents it becomes ethically inappropriate behaviour and could be considered as the above identified behaviour.

- On an identified date the first dose of the identified drug was administered. Review of resident #005's Electronic Medical Administration Record (eMar) for an identified period did not include all the above drugs therapy recommended by the specialized team.

According to the progress note with a specified date, resident #005's Substitute Decision Maker (SDM) told the home that they were not surprised as resident #005's has a history of the above identified behaviour.

Review of resident #005's progress notes indicated an identified responsive behavior toward co-residents. Further review of resident #005's progress notes for an identified period indicated the following:

A) Five incidents of the above identified responsive behaviour toward resident #010.

Review of resident #010's current MDS, indicated that the resident was severely cognitive impaired. Resident #010 ambulated independently with a walker on the unit.

B) Five incidents of the above identified responsive behaviour toward resident toward resident #014.

Review of resident #014's current MDS assessment, indicated that the resident was severely cognitive impaired. Resident #014 ambulated independently with a walker on the unit.

C) One incident of the above identified responsive behaviour toward resident toward resident #015.

Review of resident #015's current MDS assessment, indicated that the resident was severely cognitive impaired. Resident #015 required wheelchair with one staff assistance for locomotion.

D) Two incidents of the above identified responsive behaviour toward resident toward resident #013

Review of the resident's current written plan of care indicated that resident #013 was extensively confused due to specified medical condition, and had difficulty communicating with staff daily as they cannot comprehend or express themselves daily.

E) One incident of the above identified responsive behaviour toward resident toward resident #011

Review of resident #011's current MDS assessment indicated that the resident was severely cognitive impaired. Resident #011 required wheelchair with one staff assistance for locomotion.

F) One incident of the above identified responsive behaviour toward resident toward resident #012

Review of resident #012's current MDS assessment, indicated that the resident had a specified medical condition, was moderately cognitive impaired. Resident #012 required wheelchair with one staff assistance for locomotion.

Review of health record for residents #010, #011, #012, #013, #014 and #015 indicated that they were not assessed for their ability to provide consent for the above identified behaviour after each identified incident. Review of resident #005 care plan did not identify any interventions specific preventing the above identified behaviour toward the above-mentioned residents.

In an interview, RN #116 stated that resident #005 exhibited inappropriate behaviors including making inappropriate comments to staff. RN #116 indicated that after the alleged abuse involving resident #013 on an identified date, both residents were separated and closely monitored. Resident #005 was redirected, educated and was being watched not to stay close to co-residents. RN #116 indicated that resident #011 and #013 were wheelchair bound, so they were placed near the nursing station for staff to keep an eye on them.

After reviewing the residents' written plan of care, RN #116 stated that there were no specific interventions in place to protect residents #010 and #012 from the abuse by resident #005 as they ambulate independently with a walker. RN #116 acknowledged that staff monitor them and do not let them sit near resident #005, but it was not possible all the time.

In an interview, RPN #115 indicated that resident #005 exhibited inappropriate behavior toward co-residents and staff. Resident #005 rarely exhibited another identified behaviour. RPN #115 indicated that there was no specific intervention in place, but when the incident occurred, staff move the co-resident away from resident #005 and that environment, place them by the nursing station and closely monitor them. The RPN indicated that the plan was to initiate Dementia

Observation System (DOS) to monitor resident #005 and to refer the resident to the Geriatric Mental Health Outreach Team (GMHOT) and Leap of Faith Together (LOFT) team. RPN #115 indicated that resident #005 liked to sit with residents #010 and #012, and sometimes held hands with both residents but sometimes while having conversations resident #005 would exhibit the behaviour mentioned above.

In a joint phone interview, the ED and DOC indicated that the initial referral to GMHOT for resident #005's inappropriate behaviour is on an identified dated in 2019, and the resident is being assessed monthly by the GMHOT team. They indicated that the GMHOT team had discussed the resident's inappropriate behaviour while assessing the resident for the other responsive behaviour. The recommendations were made but the family did not consent for several weeks after the recommendations. The DOC indicated that on an identified date GMHOT recommended a specified medication, but the home's physician did not carry out the recommendation. The DOC and ED also stated that resident #005's SDM refused to consent to any treatment until June 20, 2019. The resident had scheduled specified medication daily. The ED indicated that all the residents involved in the incident mentioned above, did not have an assessment to consent to specified activities.

Through record review and the interviews, resident #005 was abusing vulnerable residents who were moderately and severely cognitively impaired for eight months period. While all staff interviewed understood that resident #005's behavior constituted a specified abuse of the six vulnerable residents, and in fact had reported their concerns to the management of the home, there were minimal interventions in place to mitigate the risk. The management team stated that they were aware of the alleged incidents of abuse mentioned above. They stated that the current residents' written plan of care did not identify interventions to address the risk and prevent re-occurrence. As a result, the inspector concluded that the home had not taken appropriate steps to protect resident #010, #011, #012, #013, #014 and #015.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the residents. The scope was determined to be level two as six out of nine residents were victim of abuse. The home had a level two compliance history as they had previous non-compliance in different sub-

section. As a result of actual harm/risk to the resident, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with 20. (1) of the LTCHA, 2007.

Specifically the licensee shall do the following:

1. Investigate all identified incidents of alleged abuse.

2. Notify the Substitute Decision Maker (SDM) of any incident of abuse involving their family member who lives in the home.

3.Report the identified alleged incidents of abuse immediately to the Director under the LTCHA, 2007.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

During the inspection related to resident #005's responsive behaviours, the inspector identified in the resident's progress notes, multiple incidents of abuse toward residents #010, #011, #012, #013, #14 and #15.

The staff of the home did not comply with the following sections of the licensee's Prevention of Abuse and Neglect of a Resident policy, VII-G-10.00, revised on April 2019:
-All team members (employees, volunteers, agency staff private duty caregivers, contracted service providers), resident and families are required to immediately

report any suspected or known incidents of abuse or neglect to the provincial health authorities.
-Inform the Power of Attorney for care or the SDM immediately (if the resident is not capable) of the alleged abuse if the incident has caused harm, pain, or distress to the resident.
-The Executive Director or designate initiates the investigation.

Review of the progress notes of resident #005 indicated the following incidents of identified behaviour toward six residents for an identified period as follows:
- five incidents of the above identified responsive behaviour toward resident #010.
- One incident of the above identified responsive behaviour toward resident toward resident #015.
- Two incidents of the above identified responsive behaviour toward resident toward resident #013.
- One incident of the above identified responsive behaviour toward resident toward resident #011.
- One incident of the above identified responsive behaviour toward resident toward resident #012.

Review of residents #010, #011, #012, #013, #14 and #15's progress notes indicated that the residents' SDM were not notified about the incidents related to the identified responsive behaviour mentioned above, except one incident. Further review of the home's records did not identify the home's investigation notes for the above-mentioned incidents.

A review of the progress and the CIS report indicated that the home had not reported to the Director under the LTCH Act 2007, and not investigated the incidents mentioned above.

Interview with the RPN #115 and nurse manager (NM) #116 indicated that resident #005 exhibited the identified responsive behaviour toward residents #010, #011, #012, #013, #14 and #15. NM #116 indicated that the above-mentioned incidents were documented on the progress notes, but they were not investigated, the Director under the LTCHA, 2007, was not informed and the residents' SDM were not notified.

In a joint interview, DOC and ED confirmed that resident #005 exhibited the identified responsive behaviour toward to residents #010, #011, #012, #013, #14 and #15. Both the DOC and ED acknowledged that the home's Prevention of Abuse and Neglect of a Resident policy was not complied with as they did not notify the residents' SDM, report the alleged incident of abuse to the Director under the LTCHA 2007, and did not investigate them immediately.

Through record review and the interviews, resident #005 was exhibiting the identified behaviour toward vulnerable resident who were moderately and severely cognitively impaired for an identified period. All staff that were interviewed understood that resident #005's behavior constituted a specific abuse of the six vulnerable residents, and in fact had reported their concerns to the management of the home. The home did not notify the residents' SDM, report the alleged incidents of abuse to the Director under the LTCHA 2007, and did not investigate them immediately.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the residents. The scope was determined to be level two as six out of nine residents were victims of abuse. The home had a level two compliance history as they had previous non-compliance under a different sub-section. As a result of actual harm/risk to the resident, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Toronto Service Area Office