Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Sep 24, 2020	2020_631210_0012	004232-20, 009512-20, 015717-20	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

SLAVICA VUCKO (210)

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): September 01, 02, 03, 08, 09, 10 and 11, 2020.

During the course of the inspection, the following Critical Incident System (CIS) intakes were inspected:
-Log #004232-20 (CIS #2918-000002-20) and Log # 009512-20 (CIS#2918-000007-20) related to falls prevention and management, and
-Log # 0015717-20 (CIS #2918-000016-20) related to resident's hospitalization and change in health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of care (ADOC), Manager of Environmental Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Personal Support Workers (PSWs) and Clinical Consultant from the Medical Devices supply company.

The inspector conducted observations of staff and resident interactions, provisions of care, reviewed residents' clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complement each other.

A Critical Incident Report (CIS) was submitted to Ministry of Long Term Care (MLTC) indicating that on a specified date and time resident #001 was found on the floor and was transferred to hospital because of a body injury.

A review of resident #001's clinical record indicated they used a wheelchair for mobility and was not able to call for help when needed.

Interview with a PSW indicated on a specified date and time resident #001 was in bed and they asked the resident one time if they wanted to go to washroom. The resident refused. According to staff they did not ask the resident to come to the dining room sometime after they asked for toileting, because they planned for the resident to have tray service in their room.

Interview with the unit RPN indicated they went to check resident #001 the moment they noticed they were not in the dining room. When they went into resident #001's room, they found them on the floor beside their bed. The RPN indicated they were not informed that the resident would not come to the dining room for dinner.

A review of resident #001's clinical record and interviews with registered staff and PSWs

indicated it was not a usual routine for the resident to stay in bed during dinner. Interview with ADOC #105 indicated it was the home's expectation when a resident refuses care to be re-approached three times, and the registered staff to be informed for further assessment. The above- mentioned interviewed staff acknowledged that the staff did not follow the process for proper collaboration. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A CIS was submitted to MLTC indicating that on a specified date, resident #003 was diagnosed with an injury and it was treated in hospital. The home indicated the injury was from unknown cause.

A review of resident #003's clinical record indicated the resident used a wheelchair for mobility and required total care for all activities of daily living. The staff noted a change in the skin integrity on a part of the resident's body one week before it was diagnosed.

A review of the bath schedule indicated resident #003 had a shower two times a week before the injury was noted. The care plan of the resident indicated they required two-person assistance for shower.

Interview with a PSW indicated they provided a shower to resident #003 on two weeks before the injury was identified, by themselves. The staff further indicated that if the care plan indicated two-person assistance for shower, it applies to the transfer only, and that the actual shower is performed by one staff. The PSW explained that the second staff is called before and after the shower and they leave the shower room during the shower.

Interviews with PSWs, RPN and ADOC indicated that if the resident's care plan indicates that the resident requires two-person assistance for shower, it means that two staff should be assisting with providing the shower, which was not a case with resident #003. [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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and that the care set out in the plan of care was 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids (shower chairs) are appropriate for the resident based on the resident's condition.

A CIS was submitted to MLTC indicating that on a specified date, resident #003 was diagnosed with an injury and it was treated in hospital. The home indicated the injury was from unknown cause.

A review of resident #003's clinical record indicated the resident used a wheelchair for mobility and required total care for all activities of daily living. The staff noted a change in the skin integrity on a part of the resident's body one week before it was diagnosed. Prior to that, the resident was provided showers twice a week.

A review of several random residents' written plan of care did not indicate which type of shower chair to be used during shower.

During observation on a specified date, the inspector noted five types of shower chairs in the shower room of the main floor unit.

During interviews with registered staff and several PSWs on the unit, they were not able to explain the assessment criteria for determining the type of shower chair to be used according to residents' condition. They indicated that the type of shower chair was not specified in the residents' care plan. One of the PSWs was using the shower chair without the tilt feature and others did not remember.

Interview with the Clinical Consultant from the Medical Devices supply company, indicated that there are assessment criteria for the residents and the use of shower chairs, according to the specific condition of the resident and manufacturers instructions. They were shared with the home during yearly education.

During interviews with the ED, DOC and ADOC, they were not able to demonstrate that the home had a process for assessing the residents for appropriate use of the shower chairs according to residents' condition. [s. 30. (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 where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure the incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was investigated, appropriate action was taken in response to every such incident; and any requirements that are provided for in the regulations for investigating and responding as required.

A CIS was submitted to MLTC indicating that on a specified date, resident #003 was diagnosed with an injury and it was treated in hospital. The home indicated the injury was from unknown cause.

A review of resident #003’s clinical record indicated the resident used a wheelchair for mobility and required total care for all activities of daily living. The staff noted a change in the skin integrity on a part of the resident’s body one week before it was diagnosed. The resident was treated for a different suspected condition before it was diagnosed as an injury.

The inspector discussed with the DOC and ADOC that for an injury of unknown cause for a resident who requires total care, the home should have investigated possible improper care, and/or revise the care plan.

During interviews with the DOC and ADOC, they were not able to demonstrate that the home investigated the cause of resident #003’s injury, such as interviewing staff, reviewing the camera footage or identifying if the care was provided according to the care plan, as they did in a similar case. [s. 23. (1)]

Issued on this 16th day of October, 2020

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

Original report signed by the inspector.