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

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 14, 2021	2021_751649_0005	000748-21	Complaint

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 19, 22, 23, 24, 25, 26, March 2, 3, 4, 5, 7 (off-site), 8, 9, and 10, 2021.

The following intake was completed during this Complaint Inspection:
Log #000748-21 related to housekeeping and pest control.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Environmental Services (DES), Director of Dietary Services (DDS), Registered Practical Nurse (RPN), Housekeeping Supervisor, Personal Support Worker (PSW), Dietary Aide (DA), Abell Technician, and residents.

During the course of the inspection the inspector conducted observations related to pests and meal service delivery.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that immediate action was taken to deal with pests.

A complaint was received by The Ministry of Long-Term Care (MLTC) related to pests in the home, specifically a cockroach was observed on a resident.

Several observations of pest sightings were made by the inspector as follows:
-During a tour of the home the inspector observed a live pest (cockroach) in one of the serveries on the floor close to the fridge. Another sighting of a dead pest was observed on the counter top, close to the microwave in a home area dining room. Dead pests were observed in the cabinet (3rd drawer) on another home area in the TV room. A live pest was observed in the hallway on the main floor, while the inspector was with the Housekeeping Supervisor. This sighting was immediately brought to the Housekeeping Supervisor's attention, and they killed the pest by stepping on it.

The home provided the inspector with the result of a mass monitoring that was completed by the home's pest control company. According to this report, areas of higher infestation were mostly on two identified floors, and a couple of housekeeping areas on another floor.

A review of the home's policy #V-E-10.00, titled Pest Control with a current revision date of January 2015, indicated that home will perform monthly inspections, but there was no mention of what action the home would have taken with these inspections or their role in preventative pest control.

The DES told the inspector that when they received the mass monitoring report from the home's pest control company they had not taken any immediate action to deal with the pests. The ED was present during the interview, and said they understood that the home had not taken immediate action with regards to the mass monitoring report.

Sources: Inspector #649's observations, the home's pest control company mass monitoring report, interviews with complainant, DES, and ED. [s. 88. (2)]

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #649 was conducting an observation of a home area when a resident's family member told the inspector that a resident did not have their lunch. The resident was observed in their mobility device in their room. This concern was brought to the unit nurse's attention. The inspector observed the nurse remove the lunch meal from resident's room, took it to the dining room and re-heated it in the microwave. The resident was provided meal assistance by a nursing student.

According to the PSW who had served the resident their meal, they indicated that they had served the resident approximately 30 minutes earlier. They had served all residents but did not provide the assistance required as they also had residents to assist with their meal. According to resident's family member the resident was served lunch approximately 60 minutes earlier. The unit nurse confirmed that the meal tray should not have been left in the resident's room until there was someone available to provide the resident with assistance.

This concern was brought to the ED's attention.

Sources: Inspector #649's observations, interview with resident's family member, unit nurse, and PSW. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 19th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649)
Inspection No. / No de l'inspection :	2021_751649_0005
Log No. / No de registre :	000748-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 14, 2021
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 Long-Term Care

Ministère 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 Long-Term Care

Ministère 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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Order / Ordre :

The licensee must be compliant with s. 88 (2) of O. Reg. 79/10.

Specifically, the licensee must:
1. Upon receipt of the mass monitoring report from the home's pest control company, the home must take immediate action to deal with pests.
2. Update their policy to include preventative and integrated pest management. The home must maintain detailed documentation of the services provided from the home's pest control company during each visit, including the dates of service, the type of service provided, and what areas of the home received treatment.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that immediate action was taken to deal with pests.

A complaint was received by The Ministry of Long-Term Care (MLTC) related to pests in the home, specifically a cockroach was observed on a resident.

Several observations of pest sightings were made by the inspector as follows:
-During a tour of the home the inspector observed a live pest (cockroach) in one of the serveries on the floor close to the fridge. Another sighting of a dead pest was observed on the counter top, close to the microwave in a home area dining room. Dead pests were observed in the cabinet (3rd drawer) on another home area in the TV room. A live pest was observed in the hallway on the main floor, while the inspector was with the Housekeeping Supervisor. This sighting was immediately brought to the Housekeeping Supervisor's attention, and they killed the pest by stepping on it.

The home provided the inspector with the result of a mass monitoring that was completed by the home's pest control company. According to this report, areas of higher infestation were mostly on two identified floors, and a couple of housekeeping areas on another floor.

A review of the home's policy #V-E-10.00, titled Pest Control with a current revision date of January 2015, indicated that home will perform monthly inspections, but there was no mention of what action the home would have taken with these inspections or their role in preventative pest control.

The DES told the inspector that when they received the mass monitoring report from the home's pest control company they had not taken any immediate action to deal with the pests. The ED was present during the interview, and said they understood that the home had not taken immediate action with regards to the mass monitoring report.

Sources: Inspector #649's observations, the home's pest control company mass monitoring report, interviews with complainant, DES, and ED.

An order was issued based on the following factors:

Severity: Three and more resident areas and other home areas within the home were identified with areas of pest infestation and indicating minimal harm or risk.

Scope: The scope of the non-compliance was identified as a pattern.

Compliance history: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months.

(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 2021

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 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 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 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 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 14th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

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