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
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5700, rue Yonge 5e étage
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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
Jun 7, 2021	2021_804649_0009	001462-21, 003458-21, 003481-21, 004347-21, 004439-21, 006614-21	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

JULIEANN HING (649)

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): April 29, 30, May 4, 5, 6, and 7, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Logs #001462-21, CIS #2918-000003-20, #004347-21, CIS #2918-000011-21, #006614-21, CIS #2918-000024-21, #003481-21, CIS #2918-000007-21 - related to falls prevention and management,
Log #003458-21, CIS #2918-000008-21 - related to responsive behaviours,
Log #004439-21, CIS #2918-00012-21 - related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Physiotherapist (PT), Resident Assessment Instrument- Minimum Data Set (RAI-MDS) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Coronavirus disease (COVID) Screener, and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations, reviewed residents' clinical records, staffing schedules, and observed Infection Prevention and Control Practices (IPAC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

The home submitted a Critical Incident System (CIS) report related to a resident's fall that resulted in an injury. The resident's care plan indicated that they required the use of a mechanical lift for toileting. According to the PSW they would leave the resident on the toilet for long periods of time as requested by the resident's substitute decision-maker (SDM). The resident became sleepy after sitting on the toilet for a long period of time and fell from the mechanical lift, that resulted in an injury related to the PSW's unsafe positioning of the resident.

Further review indicated that the resident sustained a previous fall a couple of months prior to the above mentioned incident that resulted in an injury. The PT was told by the PSW that they had removed the mechanical lift while the resident was on the toilet which led to the resident's fall and injury. According to the PT's documentation and interview, they had spoken with the PSW after the resident fell and told them not to remove the lift while the resident was on the toilet, and to stay with the resident when toileting. The resident's care plan was updated to reflect not to leave the resident unattended during toileting for safety. This unsafe practice of the PSW led to the resident's fall and injury, and further resulted in the second fall mentioned above and further injury.

The PT and DOC both acknowledged that unsafe transferring and positioning techniques were used by the PSW during care of the resident.

Sources: resident's health records, home's investigation notes, interview with the PSW and other staff. [s. 36.]

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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a CIS report related to a resident, who sustained a fall with injury. No post-fall assessment was completed when the resident sustained the fall with injury. The RPN told the inspector they had completed a post-fall assessment for the resident's fall but was unable to locate the documentation. The resident sustained another fall a few days later, this post-fall assessment was mistakenly attached as the completed post-fall assessment for the resident's first fall. This gap was brought to the ADOC's attention who acknowledged that a post-fall assessment was not completed after the resident's first fall.

Sources: resident's health records, interview with the RPN and other staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective and when the residents' care needs changed.

The home submitted a CIS report related to a resident, who sustained a fall with injury. The resident's falls care plan indicated the use of a specific device. Observation conducted by the inspector did not indicate use of a specific device. The resident was observed sitting outside their room and no specific device was noted to be in use.

The PSW told the inspector that the resident no longer required use of the specific device as they were now walking. According to the PSW it had been approximately 10 days since the resident's mobility device was removed, therefore they no longer required the use of the specific device. The PT told the inspector that the resident no longer required use of a mobility deivce. A review of the PT's documentation indicated they documented the removal of the resident's mobility device approximately two weeks prior to the inspector's observation. This concern was brought to the ADOC and RPN's attention and they both acknowledged that the resident's care plan should have been updated and revised after the removal of the specific device.

Sources: resident's health records, interview with the PSW and other staff. [s. 6. (10) (b)]

Issued on this 15th day of June, 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_804649_0009
Log No. / No de registre :	001462-21, 003458-21, 003481-21, 004347-21, 004439-21, 006614-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 7, 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

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

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36. of O. Reg. 79/10.

Specifically, the licensee must:
1. Retrain PSW #108 on the home's Lift and Transfer Policy. The training should include safe positioning techniques during all aspects of resident's care, and a test component to evaluate PSW #108's understanding of safe positioning techniques.
The home must maintain a record of the education and training provided, including the dates the education was provided, who provided the education, and signed staff attendance records.

2.Conduct weekly observations of PSW #108's transfers techniques to ensure safe positioning of resident #003 and any other applicable residents for a period of four weeks.
The home must maintain a record of the observations, including the dates the observations were made, who conducted the observations, and PSW #108's signed acknowledgement of any feedback provided.

3. Provide PSW #108 an opportunity to meet with their manager/supervisor to discuss any concerns they have experienced related to residents' transfers and positioning techniques.
The home must maintain written documentation summarizing what was discussed, the name of the resident discussed, the date of the discussion, name of manager/ supervisor who participated in the discussion, and the outcome of the discussion.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #003.

The home submitted a Critical Incident System (CIS) report related to resident #003's fall that resulted in an injury. Resident #003's care plan indicated that they required the use of a mechanical lift for toileting. According to PSW #108 they would leave resident #003 on the toilet with the washroom door closed for long periods of time as per the resident's substitute decision-maker (SDM) request. The resident became sleepy after sitting on the toilet for approximately one hour and fell from the mechanical lift, that resulted in an injury related to PSW #108's unsafe positioning of resident #003.

Further review indicated that resident #003 sustained a previous fall a couple of months prior to the above mentioned incident that resulted in an injury. PT #107 was told by PSW #108 that they had removed the mechanical lift while the resident was on the toilet which led to the resident's fall and injury. According to the PT's documentation and interview, they had spoken with PSW #108 after the resident fell and told them not to remove the lift while the resident was on the toilet, and to stay with the resident when toileting. The resident's care plan was updated to reflect not to leave the resident unattended during toileting for safety. This unsafe practice of PSW #108 led to the resident's fall and injury, and further resulted in the second fall mentioned above and further injury.

PT #107 and DOC #121 both acknowledged that unsafe transferring and positioning techniques were used by PSW #108 during care of resident #003.

Sources: resident #003's health records, home's investigation notes, interview with PSW #108 and other staff.The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

The home submitted a Critical Incident System (CIS) report related to a resident's fall that resulted in an injury. The resident's care plan indicated that they required the use of a mechanical lift for toileting. According to the PSW they would leave the resident on the toilet for long periods of time as requested by the resident's substitute decision-maker (SDM). The resident became sleepy after sitting on the toilet for a long period of time and fell from the mechanical lift,

that resulted in an injury related to the PSW's unsafe positioning of the resident.

Further review indicated that the resident sustained a previous fall a couple of months prior to the above mentioned incident that resulted in an injury. The PT was told by the PSW that they had removed the mechanical lift while the resident was on the toilet which led to the resident's fall and injury. According to the PT's documentation and interview, they had spoken with the PSW after the resident fell and told them not to remove the lift while the resident was on the toilet, and to stay with the resident when toileting. The resident's care plan was updated to reflect not to leave the resident unattended during toileting for safety. This unsafe practice of the PSW led to the resident's fall and injury, and further resulted in the second fall mentioned above and further injury.

The PT and DOC both acknowledged that unsafe transferring and positioning techniques were used by the PSW during care of the resident.

Sources: resident's health records, home's investigation notes, interview with the PSW and other staff.

An order was issued based on the following factors:
Severity: One resident experienced actual harm.
Scope: The scope of the non-compliance was identified as isolated because one resident experienced a change in health status.
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 : Jul 21, 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 7th day of June, 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