Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 9, 2022	
Inspection Number: 2022-1402-0003	
Inspection Type: Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Norfinch Care Community, North York	
Lead Inspector Noreen Frederick (704758)	**Inspector Digital Signature**
Additional Inspector(s) Henry Chong (740836) Maya Kuzmin (741674)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21, 2022
November 22, 2022
November 23, 2022
November 24, 2022
November 25, 2022
November 28, 2022
November 29, 2022

The following intake(s) were inspected:
- Intake: #00002924- [CI: 2918-000006-22] Improper transfer with injury
- Intake: #00003137- [CI: 2918-000008-22] Fall with Injury
- Intake: #00003330- [CI: 2918-000027-21] Improper transfer with injury
- Intake: #00003456- [CI: 2918-000037-21] Resident to Resident physical abuse
- Intake: #00003474- [CI: 2918-000035-21] Fracture etiology unknown.
- Intake: #00004879- [CI: 2918-000063-21] Hypoglycemia

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The following intake(s) were completed:

- Intake: #00002953- [CI: 2918-000029-21] Fall with Injury
- Intake: #00002986- [CI: 2918-000036-21] Fall with Injury
- Intake: #00003021- [CI: 2918-000048-21] Fall with Injury
- Intake: #00003023- [CI: 2918-000038-21] Fall with Injury
- Intake: #00003352- [CI: 2918-000030-21] Fall with Injury
- Intake: #00003357- [CI: 2918-000046-21] Fall with Injury
- Intake: #00003457- [CI: 2918-000034-21] Fall with Injury
- Intake: #00003459- [CI: 2918-000041-21] Fall with Injury
- Intake: #00003505- [CI: 2918-000053-21] Fall with Injury
- Intake: #00003543- [CI: 2918-000033-21] Fall with Injury
- Intake: #00004082- [CI: 2918-000026-21] Fall with Injury
- Intake: #00004518- [CI: 2918-000014-22] Fall with Injury
- Intake: #00006083- [CI: 2918-000059-21] Fall with Injury
- Intake: #00006100- [CI: 2918-000060-21] Fall with Injury

The following **Inspection Protocols** were used during this inspection:

Responsive Behaviours
Prevention of Abuse and Neglect
Infection Prevention and Control
Resident Care and Support Services
Medication Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the infection prevention and control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that that there is in place a hand hygiene program in accordance with the “Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022” (IPAC Standard). Specifically, the IPAC lead did not ensure that the hand hygiene program includes 70-90% alcohol-based hand rub as is required by Additional Requirement 10.1 under the IPAC Standard.

On November 21, 2022, one 60% ABHR was observed at the entrance of the Long-Term Care home. Associate Director of Care (ADOC) acknowledged that a minimum of 70% ABHR should be used in the home. ADOC and Director of Care (DOC) removed the 60% ABHR upon becoming aware. There was an increased risk of transmission of infection to staff and residents.

Sources: Inspector's observations on November 21, 2022, and interview with ADOC.

[740836]

Date Remedy Implemented: November 21, 2022

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (1)

In accordance with O. Reg 79/10 s. (49)(1) in reference to s.(8)(1)(b), the licensee is required to comply with the falls prevention and management program.

Specifically, Personal Support Worker (PSW) did not comply with the Long-Term Care Home (LTCH)'s policy and procedure "Falls Prevention and Management - VII-G-30.10", last revised December 2021. The LTCH policy requires that when a fall occurs that all team members will ensure the resident is not moved before the completion of a preliminary assessment.

Rationale and Summary
A resident fell and a PSW transferred the resident back to bed and did not report the fall to the Registered Practical Nurse (RPN). Therefore, the PSW did not comply with the policy and procedure for the resident during this time.

Sources: Critical Incident System (CIS) report # 2918-000027-21, The LTCH's investigation notes, resident's clinical record, Falls Prevention and Management Policy- VII-G-30.10, interview with RPN and ADOC.

[741674]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that that when a resident fell, they were assessed post-fall.

Rationale and Summary
The home submitted a CIS report, when the resident sustained injuries from a fall.

A resident had a fall and the PSW did not reveal the details of the fall to the RPN. As a result, no post-fall assessment was completed for this fall. RPN and DOC stated that no post-fall assessment was completed for the resident when they fell.

The resident did not receive any assessment by registered staff after their fall, which delayed treatment and care for their injuries.

Sources:
Resident's clinical records, home's investigation notes, and interviews with RPN and DOC.

[704758]

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WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 48 (1) 1.

The licensee has failed to ensure that home's interdisciplinary falls prevention and management program was implemented.

Rationale and Summary
Resident Falls Prevention Program, XV-B-10.30 last revised October 2021, (pg.2) stated "Falls Committee members: will review all falls that occurred since the last meeting-recommend and oversee implementation of risk minimization strategies and interventions. Review and assurance of compliance with the falls prevention policy. Completion of quarterly audit of falls and applicable action plan".

A resident had 9 falls over an eight-month period. ADOC/Falls Lead stated that they did not review and assure compliance with fall prevention policy, did not complete quarterly audits and action plan, and the falls committee did not review, make recommendation, or implement risk minimization strategies and intervention for the resident as required by the home's Falls Prevention Program.

Due to the home not implementing Resident Falls Prevention Program, there was missed opportunity to identify fall preventing and management strategies and interventions to reduce or minimize the occurrence of residents falls.

Sources:
Resident Falls Prevention Program, XV-B-10.30 (last revised October 2021), and interview with ADOC/Falls Lead.

[704758]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee has failed to ensure that a resident was provided with falls prevention and management interventions as specified in their care plan.

Rationale and Summary
The home submitted a CIS report, when a resident sustained an injury after a fall.

The resident was to be provided with three specific falls prevention and management interventions. Two observations were conducted by inspector #704758, which revealed that the resident did not have these interventions in place. PSW stated that they did not provide these interventions to the resident as specified in their care plan.

DOC stated that the falls interventions set out in the care plan were not provided to the resident.

The resident was not provided with falls prevention and management interventions as specified in their care plan, placing them at risk for fall with injury.

Sources:
Inspector's observations, resident 's clinical records, and interviews with PSW and DOC.

[704758]

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed and their care plan was reviewed and revised when their falls prevention and management interventions were ineffective.

Rationale and Summary
A resident was at risk of falls and had 7 falls in three months. Their care plan stated that the resident refuses fall prevention interventions. RPNs and Registered Nurse (RN) stated that they were aware that the interventions in place were ineffective, but they did not reassess the

resident and did not review and revise the care plan.

ADOC/Falls Lead, and DOC stated that the resident was not reassessed, and care plan was not reviewed and revised when falls prevention and management interventions were ineffective.

Due to the home not reassessing and reviewing and revising care plan related to ineffective falls prevention and management interventions, the resident continued to be at risk of falls with injuries.

Sources:
Resident 's clinical records, and interviews with RPNs, RN , and ADOC/Falls Lead.

[704758]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident after a fall.

Rationale and Summary
After the resident fell, the PSW solely completed the transfer of resident using a mechanical lift and another resident's sling. In an interview, ADOC acknowledged that the resident was improperly transferred by the PSW . The resident was sent to hospital and returned to LTCH on the following day with an injury and an increase in pain medication. As a result of improper transferring techniques by the PSW, the resident was placed at higher risk of fall and injury.

Sources: Critical Incident System (CIS) report #2918-000027-21, LTCH's investigation notes, Safe Resident Handling Policy, VII-G-20.30 (dated April 2019), resident's clinical records, and interview with ADOC.

[741674]