Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 08, 2023
Inspection Number: 2023-1402-0004
Inspection Type: Complaint 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	**Inspector Digital Signature**
Parimah Oormazdi (741672)	Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.03.10 14:11:50 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 16 - 17, 21 - 24, 2023

The following intake(s) were inspected:

- Intake: #00017017 was related to prevention of abuse and neglect
- Intake: #00019422 was related to falls prevention and management.
- Intake: #00020914 was related to falls prevention and management and skin and wound care.

The following intakes were completed in the Critical Incident System Inspection:

- Intake: #00014454 was related to falls prevention and management.
- Intake: #00017911 was related to falls prevention and management.
- Intake: #00019048 was related to falls prevention and management.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours

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).
FLTCA, 2021, s. 184 (3)

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022:
- 8. Licensees are required to ensure that the COVID-19 asymptomatic screen testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed. Specifically, when the staff who were assigned as a COVID-19 screener, as well as tester were not available at home's entrance door to ensure Rapid Antigen Test (RAT) is completed for staff and visitors.

Rationale and summary:
Through an observation of COVID-19 screening/ testing process, it was observed that a visitor entered the Long Term Care (LTC) home and proceeded to elevator and entered the residents' home area without any staff member of the LTC home checking if this visitor had required to do a RAT prior to entering the residents' home area.

Upon their entrance to the home, there was not any staff member available, nor at screening desk neither at COVID-19 Rapid Antigen testing station, to verify if they require to complete Rapid Antigen Test (RAT). It was also observed that the receptionist who supposed to provide coverage in absent of screener/ tester, was busy answering the phone at reception desk which was located far from entrance door, and they did not pay attention to the visitor who entered the home.

One of the COVID-19 screening questions that visitors supposed to complete upon their entrance to the home at electronic screening kiosk indicated "to see the screener to receive Rapid Antigen Test if the

RAT is not completed in last two days, and if they have completed the RAT they should show the proof to the screener."

The screener/ tester staff stated that all visitors should show them the proof of RAT being completed in last two days upon their entrance to home, so that they are aware if RAT is required to be completed or not.

The Associate Director Of Care (ADOC) who was also assigned to IPAC lead position stated that there should be a screener/tester available at screening desk all the time. The screener / tester staff is assigned to monitor the staff and visitors who are entering the home and ensure to complete the RAT for those who have not received the RAT in past two days. They also stated that when the screener/ tester staff is on their break, the receptionist supposed to actively be present at screening desk and monitor all the visitors and staff who are entering the home.

The ADOC/ IPAC lead was acknowledged and afterwards there was a screener/ tester staff available at screening desk all the time during the inspection.

Sources: COVID-19 screening/ testing observation, interview with ADOC and Screener/ tester staff. [741672]

Date Remedy Implemented: February 16, 2023.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 3.

The licensee has failed to ensure that the IPAC lead designated under this section worked regularly in that position on site at the home, with a licensed bed capacity of 160 beds, for at least 26.25 hours per week.

Rationale and summary:
During interview with the ADOC who was also assigned to the IPAC lead role, they indicated that they had not designated a minimum number of weekly hours for the IPAC lead position. The number of hours would vary from day to day based on their workload. They worked less than required 26.25 hours per week towards the IPAC duties and the rest of the work day was dedicated to the ADOC role. They also

stated that during a period in the year of 2022, that the home was in a process of hiring an IPAC lead, the ADOC assumed the IPAC Lead duties, while in their ADOC role.

The Director of Care (DOC) stated that the home had a licensed bed capacity of 160 beds and one of their ADOCs was also the home's designated IPAC Lead until they hire a qualified staff member who will fully take over the IPAC lead position. They confirmed that the working hours provided to the ADOC during at the time of this inspection was not adequate to accomplish IPAC lead responsibilities and their contingency plan does not fulfill the IPAC lead hours.

The home's job description and job routine of the IPAC lead did not include any designated working hour for the IPAC lead. There was no record that indicated IPAC lead hours were monitored and met the required minimum amount of time per week.

The non-compliance caused a risk of impact to the implementation of the home's IPAC program.

Sources: Home's IPAC lead job description and job routine; interviews with ADOC/ IPAC lead and the DOC.
[741672]

WRITTEN NOTIFICATION: 24-HOUR ADMISSION CARE PLAN

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 27 (2) 3.

The licensee failed to include the type and level of assistance required relating to Activities of Daily Living (ADL), walking and locomotion in a resident's 24-hour care plan.

Rationale and summary:
A resident had a fall incident within 24 hours of their admission to the home. The fall incident happened when they were ambulating in an unsafe manner without any staff assistance. As a result of fall incident, the resident sustained injury.

The admission assessment tool that was completed upon the resident's admission to the home, indicated a type of ambulation assistance required. However, the 24-hour care plan developed by the staff of the home did not include the intervention of type of assistance.

A Registered Practical Nurse (RPN) stated that the 24-hour care plan should be initiated upon the resident's admission and after completing the residents' admission assessment, all the ADL related interventions should be added in 24-hour care plan, so that all staff will be aware of the interventions. They also stated that if a resident requires a type of assistance, staff should provide the support required with their type of ambulation assistance. The ADOC and DOC also confirmed that the 24-hour care plan should have included the type and level of assistance for all the ADLs including locomotion.

Failure to ensure the resident's 24-hour care plan included interventions to address their type and level of assistance required for locomotion, may have increased the risk of fall or injury for the resident, since the staff may not be aware of the interventions.

Sources: Critical Incident (CI) report, interview with the RPN, ADOC and DOC, resident 's clinical health records, resident 's 24-hour care plan.
[741672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a clinically appropriate assessment tool that is specifically designed for skin and wound assessment, was used to assess a resident’s skin condition.

Rationale and summary:
A resident had an altered skin integrity, however the electronic skin and wound assessment tool in Point Click Care (PCC) was not used to assess resident's skin condition.

The home's Skin and Wound Care Management protocol, VII-G-10.90, last revised on November 2021, indicates that "With a resident exhibiting altered skin integrity, the nurse will initiate and complete electronic skin and wound assessment tool."

The ADOC and DOC confirmed that this skin and wound assessment tool was not used to assess this resident's altered skin integrity.

By not using the clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, there may have been missed opportunities to monitor this resident's altered skin integrity.

Sources: Resident's clinical health records, interview with ADOC and DOC.
[741672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (ii)

The licensee failed to ensure that, a resident exhibiting altered skin integrity, receives immediate treatment and interventions to prevent infection.

Rationale and summary:
A resident had an altered skin integrity, however no immediate treatment of this resident's altered skin integrity was carried out. Few days after the area was identified, an order was provided to start a treatment for the altered skin integrity.

The home's Skin and Wound Care Management protocol, VII-G-10.90, last revised on November 2021, indicates that "With a resident exhibiting altered skin integrity, the nurse will provide immediate treatment and interventions to improve skin condition."

The ADOC and DOC indicated that soon after identifying the resident's skin issue, the registered nursing staff should have taken the required actions in order to start treatment and prevent deterioration of skin status.

By not providing immediate treatment for resident's altered skin integrity, the resident were at risk of deterioration in their altered skin integrity as a result.

Sources: Resident's clinical health records, home's Skin and Wound Care Management protocol, VII-G-10.90, last revised on November 2021, interview with ADOC and DOC.
[741672]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident who were not capable to consent, from sexual abuse by another resident.

Section 2 (3) (b) of the Ontario Regulations 256/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Rationale and Summary:
Two residents were found in a designated area having an inappropriate sexual encounter. When the PSW found both residents in that designated area, they immediately reported to the Registered Nurse (RN) and both the RN and PSW attempted to intervene in the incident. Following to the incident, both residents were assessed for their capability to consent for sexual activities, and it was recognized that one of the residents was not cognitively capable to consent.

Clinical record review of the two residents indicates that they have had sexual expression and intimacy toward each other in different occasions prior to this incident, however they were not assessed for their capability to consent to their sexual activities.

The DOC and ADOC who is also Behavioural Support Ontario (BSO) lead stated that the two residents should have been assessed for their capability to consent to sexual activities prior to this incident. They also confirmed that the alleged sexual abuse incident has occurred between the two residents since the sexual activities engaged were non-consensual.

Failing to protect the resident from sexual abuse by another resident may have caused actual harm to that resident who was abused.

Sources: Critical incident (CI) report, clinical health records of both residents, Resident Assessment Instrument – Minimum Data Set (RAI-MDS) of residents, interview with DOC and ADOC.
[741672]

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police force was immediately notified of a suspected incident of sexual abuse by a resident that may have constituted a criminal offence.

Rationale and summary:
A PSW found two residents engaged in inappropriate sexual activities in a designated area and they informed an RN immediately, however the RN did not inform the police force after being notified about the alleged resident to resident sexual abuse.

Through review of the home's investigation notes and both residents' clinical health records, there was no record of the police being notified after the alleged resident to resident sexual abuse.

The DOC and ADOC confirmed that the police force was not notified following above mentioned sexual abuse incident. They indicated that they were not aware that they should have been notifying the police force after occurrence of this incident.

The licensee's failure to immediately report an allegation of resident to resident sexual abuse to the police resulted in the lack of potential actions that can be taken by the police related to this incident.

Sources: Home's investigation notes, residents' clinical health records, interview with DOC, ADOC and RN.
[741672]