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: April 19, 2023	
Inspection Number: 2023-1402-0005	
Inspection Type: Complaint	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Norfinch Care Community, North York	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Christine Francis Digitally signed by Christine Francis Date: 2023.04.19 15:26:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-6, 11, 2023

The following intake(s) were inspected:
- Intake: #00021840 - complaint related to nutrition and hydration
- Intake: #00084468 - complaint related to skin and wound prevention and management

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)

The licensee has failed to ensure that a resident's hydration risk was identified.

Rationale and Summary
On a specified date, the resident was transferred to hospital, and their discharge diagnosis was noted to be dehydration.

The resident's care plan did not identify any risks related to hydration prior to their transfer to hospital. The home's "Hydration and Nutrition Monitoring" policy, last revised February 2022, indicated that the nurse will refer to the hydration focus in the care plan for hydration goals and care approaches, however this did not occur as the resident's care plan did not identify a hydration focus.

The Registered Nurse (RN) acknowledged that the resident was at risk of dehydration, and this was not identified in their care plan. The Director of Care (DOC) also acknowledged that the resident's care plan was missing their hydration risk prior to being transferred to the hospital, and that it should have been identified.

There was an increased risk that the resident's status could have worsened when their hydration risk was not identified in their care plan.

Sources: Interviews with RN and DOC, the resident's clinical records, and the home's "Hydration and Nutrition Monitoring" policy (last revised February 2022).

[740880]