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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: May 2, 2023	
Inspection Number: 2023-1402-0006	
Inspection Type: Proactive Compliance Inspection	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Norfinch Care Community, North York	
Lead Inspector Matthew Chiu (565)	**Inspector Digital Signature** Matthew Chiu Digitally signed by Matthew Chiu Date: 2023.05.03 11:22:57 -04'00'
Additional Inspector(s) JulieAnn Hing (649)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 13, 14, and 17-21, 2023.

The following intake(s) were inspected:

- Intake: #00085025 related to Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care revised when their care needs changed.

Rationale and Summary:
The resident was to be assisted with bathing by a specified method. The resident frequently refused bathing, and an alternate method was provided to the resident. The resident was not reassessed and their plan of care revised when their care needs and preference changed.

Sources: Resident's care plan, point of care, and assessment records; interviews with the resident, Personal Support Worker (PSW), Registered Nurse (RN), and Director of Care (DOC). [565]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident was provided a food item as set out in their plan of care.

Rationale and Summary:
Observation of the resident’s meal service indicated that they were not provided the food item. The resident's written plan of care indicated that they were on an individualized diet plan. According to the plan, they should have received one serving of the food item.

Sources: Meal service observation; resident’s care plan; interviews with the PSW, and other relevant staff. [649]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that a resident, who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary:
The resident's meal was served to them but they did not receive staff assistance until approximately 10 minutes later. The resident's care plan indicated that they were unable to feed themselves and required staff assistance with eating.

Sources: Meal service observation; resident's care plan; interviews with the PSW, and other relevant staff. [649]