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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Original Public Report

Report Issue Date: July 13, 2023	
Inspection Number: 2023-1402-0007	
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 Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.07.17 10:03:51 -04'00'
Additional Inspector(s) Kirthiga Ravindran (000760)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16, 19, 20, 2023
The inspection occurred offsite on the following date(s): June 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00087553 - Critical Incident System (CIS) #2918-000012-23 - unknown injury to a resident
- Intake: #00088376 - CIS # 2918-000013-23 - fall prevention and management, unknown injury to a resident

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary
Personal Support Worker (PSW) #110 found resident #001 requesting assistance with toileting. PSW #110 reported there was a spill. PSW #110 reported that they did not clean the floor. PSW #110 then went to call PSW #109 to assist with care and left the resident unattended. When the PSWs came back, they found the resident on the floor. The resident was attempting to get up off the floor but kept on slipping on the wet spillage on the floor. The resident had a change in condition and was later transferred to the hospital for assessment. The resident was diagnosed with an injury.

The home's policy directs staff that upon discovering blood/body spill, staff should wipe up spills immediately using a disposable towel or product designed for this purpose, and to restrict the activity around the spill until the area has been cleaned, disinfected and completely dry.

PSW #110 confirmed that they did not cleaned the spillage on the floor, and that the floor was slippery for the resident.

The Director of Care (DOC) acknowledged that the spill was a hazard for the resident and the floor should have been cleaned immediately.

Failure to clean the floor placed the resident at risk for falls.

Sources: Review of progress notes, home's investigation notes, CIS #2918-000013-23, policy titled "Bodily Fluid Spill Clean Up", index #IX-J-10.30, reviewed date April, 2022, interviews with PSW #109, PSW #110, RPN #111, RN #112, ADOC and DOC

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

1) The licensee has failed to ensure staff collaborated in the assessment of resident #002 when bruising was noted.

Rationale and Summary
PSW #100 noted bruising to an identified area of the body on resident #002 and reported to RPN #103 who did not assess the resident until two days later. On an separate date, PSW #104 reported to RPN #101 that swelling was noted to an identified area of resident #002. RPN #101 did not assess resident #002 until the family member reported to RPN #101 that resident #002 had swelling and bruising.

PSW #100 and PSW #104 indicated findings of bruising and swelling were reported. RPN #103 and RPN #101 failed to immediately assess resident #002.

The DOC acknowledged that staff are to assess the resident when there is an unusual finding immediately, document and communicate it with oncoming staff.

Failure of staff collaboration to assess resident #002, placed them at risk of delayed treatment of injuries.

Sources: Resident #002's skin and wound evaluation, POC skin observation and progress notes, home's investigation interview notes, CIS # 2918-000012-23, and interviews with PSW #100 and #104, RPN #101 and RPN #103 and other staff.

2) The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
Resident #001 had a fall in the presence of PSW #110 and PSW #109. The resident started to complain about breathing difficulty and was assessed by RPN #111. The resident had a change in condition, and was later transferred to the hospital for assessment. The resident was diagnosed with an injury.

RPN #111 reported that the PSWs did not immediately report that the resident had a fall, but they noticed that the resident was having trouble breathing and assessed the resident based on the change in condition. Registered Nurse (RN) #112 also assessed the resident and was not informed that the

resident sustained a fall. PSW #110 later told RPN #111 that the resident had a fall as the RPN was preparing to contact the physician (MD).

PSW #110 acknowledged that they did not immediately report the resident's fall. The DOC and Assistant Director of Care (ADOC) acknowledged that once a resident has fall, the PSWs are to immediately inform the registered staff of the fall in order to complete the appropriate assessments.

Failure to immediately report the fall to the registered staff, placed the resident at risk for delayed treatment.

Sources: Review of resident's progress notes, care plan, CIS #2918-000013-23, interviews with PSW #109, PSW #110, RPN #111, ADOC and the DOC.

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WRITTEN NOTIFICATION: FALLS PREVENTION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with their Falls Prevention and Management policy related to post fall management.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and be complied with.

Specifically, staff did not comply with the home's policy which indicates that upon discovering a resident has fallen, staff should:

- Ensure the resident is not moved before the completion of a preliminary assessment, and
- Complete a post falls assessment after each fall and head injury assessment as required.

Rationale and Summary:
Resident #001 had a fall. Before the resident was assessed by the registered nurse, PSW #109 and PSW #110 manually transferred the resident.

Interviews with PSW #109, PSW #110 and RPN #111 confirmed that a nursing assessment was not completed prior to moving the resident .

The DOC acknowledged that staff did not follow the home's policy of moving the resident once the registered staff completed their assessment.

Source: Review of resident's progress notes, care plan, policy titled" Fall Prevention and Management, last reviewed April 2023, interviews with PSW #109, PSW #110, RPN #111, ADOC and the DOC.

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WRITTEN NOTIFICATION: FALL PREVENTION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary:
The home used a post-fall assessment tool in Point Click Care for conducting post-fall assessment immediately after a resident fall.

PSW found resident #001 on the floor and reported it to RPN #115. The resident was transferred to the hospital due to severe pain post fall. A post-fall assessment was not completed until 19 hours later.

RPN #115 confirmed that post fall assessments should be conducted immediately and acknowledged it was not completed.

The ADOC and DOC acknowledged that staff did not immediately conduct a post fall assessment after the resident fall.

Sources: Review of resident's progress notes, assessment records; interviews with RPN #115, ADOC, and the DOC.

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