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: October 6, 2023	
Inspection Number: 2023-1402-0008	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Norfinch Community, North York	
Lead Inspector Carole Ma (741725)	**Inspector Digital Signature** Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2023.10.20 16:15:37 -04'00'
Additional Inspector(s) Manish Patel (740841)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 28, 29, October 3, 4, 2023.

The following Critical Incident (CI) intakes were inspected:

- Intake #00085070 - Related to resident-to-resident abuse
- Intake #00094299 - Related to a health emergency from a chronic disease
- Intake #00095137 - Related to COVID-19 outbreak
- Intake #00095775 - Related to a fall resulting in a significant change in condition

The following CI intake was completed during this inspection: Intake #00092226 - Related to a fall resulting in a significant change in condition.

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours

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 (4) (a)

The licensee has failed to ensure that staff involved in the different aspects of care of a resident collaborated with each other to provide assessments that were integrated, consistent and complemented each other.

Rationale and Summary
A resident was found experiencing a health emergency related to a chronic disease. A referral to a Registered Dietitian (RD), in response to this incident, was not made.

The home had two policies that indicated an RD referral was required for residents who experienced this specific health emergency.

In two separate interviews that involved independent reviews of the resident's clinical records, the Registered Practical Nurse (RPN) and the Infection Prevention and Control (IPAC) lead confirmed that an RD referral was not completed. The IPAC lead acknowledged that an RD referral should have been completed following an episode of this health emergency.

In failing to refer the resident to an RD for assessment after they experienced this health emergency, the resident was denied a more collaborative and integrated assessment of their chronic disease management strategies.

Sources: Resident's clinical records, home's policies, interviews with RPN and IPAC lead. [741725]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect resident #002 from abuse by resident #003.

O. Reg. 246/22, s. 2 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")".

Rationale and Summary
A Personal Support Worker (PSW) observed resident #003 pushing resident #002. Because of this, resident #002 sustained injuries that required transfer to another facility, and which led to a significant change in condition.

The PSW acknowledged they witnessed resident #003 pushing resident #002 which led to injuries. The Director of Care (DOC) acknowledged the abuse was substantiated based on internal investigation.

The home's failure to protect resident #002 from being abused by resident #003 resulted in injuries to resident #002.

Sources: Resident #002 and #003's chart, investigation notes, interview of PSW and DOC. [740841]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee failed to ensure that the Director was immediately informed when the home was in a confirmed COVID-19 outbreak.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Director, related to a COVID-19 outbreak that was confirmed by Toronto Public Health (TPH) two days earlier.

An internal email correspondence included an attachment that provided the confirmed outbreak date and affected resident home area. The email also indicated recommendations from TPH were being implemented that same day.

The IPAC lead acknowledged the confirmed outbreak date and admitted the home did not immediately report as required, but instead submitted the CIS report two days later.

Failing to ensure that the Director was notified immediately did not place residents at any risk.

Sources: CIS report, internal emails, interview with IPAC lead. [741725]