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: February 6, 2024	
Inspection Number: 2024-1402-0001	
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 Yannis Wong (000707)	Inspector Digital Signature Yannis Wong Digitally signed by Yannis Wong Date: 2024.02.06 13:29:48 -05'00'
Additional Inspector(s) Kirthiga Ravindran (000760)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 16, 18-19, 22-25, 2024
The inspection occurred offsite on the following date(s): January 17, 24, 2024

The following intakes were inspected in the Critical Incident (CI) inspection:

- Intake: #00098346 - [CI: #2918-000022-23] - Severe unresponsive hypoglycemia
- Intake: #00099425 - [CI: #2918-000024-23] - Fall resulting in injury
- Intake: #00103866 - [CI: #2918-000030-23] - Disease outbreak

The following intake was completed in the CI inspection:

- Intake: #00100506 - [CI: #2918-000025-23]- Fall resulting in injury

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control
Reporting and Complaints
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary
A resident had a medical condition and had a scheduled intervention to monitor their condition.

On a specified date, a Registered Practical Nurse (RPN) did not conduct the intervention scheduled for the resident at 0800 hours. The 0800 intervention was conducted at 1156 hours, along with the resident's next scheduled intervention at 1200 hours. RPN and Director of Care (DOC) acknowledged the resident's plan of care for monitoring was not followed.

Failure to ensure that a resident was monitored as per their plan of care could have

resulted in delay of receiving appropriate treatment.

Sources: Resident's clinical records; interviews with RPN and DOC. [000707]

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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were implemented.

The licensee failed to ensure that Routine Practices and Additional Precautions were followed by staff in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, a Personal Support Worker (PSW) did not apply appropriate personal protective equipment (PPE) when potentially exposed to bodily fluids, as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary
During an observation on a specified date, a PSW did not wear any PPE when assisting a resident.

The home's policy titled "Personal Protective Equipment", required staff to decide the type of PPE to be used when there is potential for direct contact with bodily fluid. Registered Nurse (RN) and IPAC Lead confirmed the PSW should have worn gloves when assisting a resident due to exposure to bodily fluids.

Failure to apply proper PPE during routine practices posed risk for transmission of infectious agents.

Sources: Observation; interviews with PSW, RN, and IPAC Lead; "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023; home's policy Personal Protective Equipment, IX-G-10.20, last revised 03/2021. [000707]

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 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed no later than one business day, of an incident that caused an injury to a resident for which the resident

was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary
A resident was transferred to the hospital and diagnosed with an injury upon admission to the hospital.

The DOC did not know how the resident sustained the injury. A critical incident system (CIS) report for this incident was not submitted to the Ministry of Long-Term Care (MLTC). The DOC confirmed the incident should have been reported to the Director.

Failure to report the incident that caused an injury to the resident where they were taken to a hospital and that resulted in a significant change in the resident's health condition did not put the resident at risk.

Sources: Review of CIS portal; resident's progress notes; interviews with DOC and other staff. [000707]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide education to RPN #113 about the home's policies related to administration of a specific high alert drug, medication administration, and documentation.
2. Maintain a record of training; including who attended the training, time and date, who conducted the training, topics covered in the training.
3. Audit medication administration process and documentation by RPN #113 for one resident per week for four weeks, or until four audits have been completed. If possible, select the specific drug or other high alert medication for the audit.
4. Maintain a record of audits; including who conducted the audit, time and date, resident audited, and actions taken in response to the audit.

Grounds
The licensee failed to ensure that a high alert medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident was found unresponsive and required medical treatment and transfer to hospital on a specified date.

The resident was scheduled to receive a high alert medication at 1200 hours. RPN #113 administered the medication at 1324 hours. A PSW documented in Point of Care (POC) at 1402 hours that the resident declined a provision related to the medication order and reported this to the nurse on shift. RPN #113 confirmed they were notified around 1400 hours. Following the receipt of this information, RPN #113 went to check on the resident but they did not conduct a relevant monitoring intervention. At the end of their shift, RPN #113 documented that they would inform the incoming shift that the resident was stable with no concerns and the monitoring intervention was within normal range.

The home's policy, "The Medication Pass", directed staff to administer time-critical scheduled medications, such as the resident's medication, at the exact time or within 30 minutes before or after the scheduled time. The DOC confirmed that RPN #113 did not follow the prescriber's directions and did not follow the home's policy on medication administration times.

Failure to ensure that a resident was administered medication at the appropriate time with the related provision resulted in a medical emergency with increased risk for negative health outcomes.

Sources: Resident's clinical records; medication administration audit; medication incident report; home's investigation notes; home's policy 5.6 "The Medication Pass", last revised June 30, 2023; and interviews with RPN #113, DOC, and other staff. [000707]

This order must be complied with by March 15, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.