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: September 27, 2024

Inspection Number: 2024-1402-0003

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Norfinch Community, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20-23, and 26-27, 2024

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00119910 - CI #2918-000014-24 was related to Fall Prevention and management
- Intake: #00121097 - CI #2918-000017-24 was related to Skin and Wound Care

The following intakes were completed in this complaint inspection:

- Intake: #00122530 was related to Skin and wound care and Plan of Care
- Intake: #00115592 was related to Improper Care and Plan of Care

The following intakes were completed in this CI inspection:

- Intakes: #00114131 - CI #2918-000007-24 and #00118043 - CI #2918-000013-24 were related to Fall Prevention and Management Program

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care sets out the planned care related to their skin and wound management.

Rationale and Summary
A resident sustained altered skin integrity and received treatment on the area by a registered practical nurse, however no records were identified that the treatment was provided to the resident. The resident's plan of care did not include the treatments for this area.

The Long-Term Care Home (LTCH)'s policy and procedure "Skin & Wound Care Management Protocol", directed staff to enter treatment orders on the resident's Treatment Administration Record (TAR) and update their care plan as appropriate.

The Registered Practical Nurse (RPN) who first identified the altered skin integrity, confirmed that they provided treatment to the site, however they did not update the resident's care plan. Another RPN stated since the treatment was not added to the resident's plan of care, there were no directions to follow, therefore no subsequent treatments were provided. The Director of Care (DOC) confirmed that when the area of altered skin integrity was identified a care plan should have been developed and the treatments should have been added to the resident's electronic clinical records.

Failure to include the resident's altered skin integrity in their written plan of care poses the risk of the resident not receiving the required treatment.

Sources: The resident's clinical records, CI report, Skin & Wound Care Management Protocol, VII-G-10.90, interviews with two RPNs, and the DOC.

[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that the effectiveness of fall prevention intervention was assessed and different approaches were considered in the revision

of a resident's plan of care.

Rationale and Summary
A resident had an unwitnessed fall when they were attempting to self-transfer and sustained an injury.

LTCH's policy and procedure "Falls Prevention and Management", indicated that " the preventative interventions should be monitored and their effectiveness should be evaluated on an ongoing basis and with the quarterly review."

The resident's clinical records indicated that they had sustained multiple falls prior to the above mentioned fall incident and were at risk of falls. The resident's care plan indicated that they had a fall prevention intervention that the resident refused. Even though the resident continued to have falls, there were no records identified to reassess the fall prevention interventions effectiveness.

A Personal Support Worker (PSW) indicated that the resident constantly refused the fall prevention device. An RPN indicated that they did not discuss with the team trialing different approaches when the resident refused the fall prevention device. The DOC acknowledged that the fall prevention interventions should have been reassessed and adjusted if they were deemed ineffective.

Failure to reassess the effectiveness of fall prevention interventions exposes the resident to further falls and injuries.

Sources: the resident's clinical records, CI report, interviews with a PSW, an RPN and the DOC, home's "Falls Prevention & Management" policy, VII-G-30.10, home's investigation notes.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA. 2021, 6 (4) (a)
Plan of Care
6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and the Registered Dietitian (RD) involved in the different aspects of care of a resident collaborated with each other, in the assessment of the resident's altered skin integrity so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
The resident developed an area of altered skin integrity area and no referral was sent to the RD related to this area. Later, the resident was assessed by the registered nurse and it was identified that the altered skin integrity was worsening. Still no referral was sent to the RD.

The RD indicated that the resident's nutritional status should have been assessed by them when the resident was first identified with altered skin integrity, as well as the time that the altered skin integrity was identified to be worsening. The RD indicated they had not been notified by nursing staff to complete an assessment of this altered skin integrity. The DOC indicated that nutritional referral should have been sent to the RD when the registered nurse identified worsening altered skin integrity.

Failure to assess the resident's altered skin condition by an RD placed them at risk for compromised healing.

Sources: The resident's clinical records, interview the with RD and the DOC.

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