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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 17, 2024
Original Report Issue Date: October 4, 2024
Inspection Number: 2024-1402-0004 (A1)
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

AMENDED INSPECTION SUMMARY

Compliance Order (CO) #001 was amended to clarify wording in the licensee report. The CO #001 is being newly issued in this Amended Inspection Report, with a served date of October 17, 2024. Compliance Order #002 and #003 are included in this report for reference; however, were not amended; therefore, the served date remains October 4, 2024.

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Lead Inspector	**Additional Inspector(s)**
Amended By	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20, 21, 22, 23, 26, 27, 29, 2024 and September 17, 18, 19, 20, 2024. An offsite interview was

conducted on October 1, 2024.

The following intakes were inspected:

- Intake: #00121697 – Critical Incident (CI) 2918-000018-24 - CI related to an allegation of abuse
- Intake: #00121710 - Complaint related to an allegation of abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance of abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the

policy is complied with.

The licensee has failed to ensure staff members complied with the home's policy to promote zero tolerance of abuse and neglect which contained procedures for responding to witnessed abuse of residents.

Rationale and Summary
The home's policy indicated that team members should immediately inform the nurse in charge of any abusive situation.

A team member observed a resident in another resident's room and suspected abuse. The residents were separated. The team member then informed other team members who all waited for the Registered Practical Nurse (RPN) to return from break to report the incident. The RPN was unsure how to proceed and called the Nurse Manger who arrived, assessed the resident and proceeded with the other actions.

The Executive Director (ED) stated that the team members who first became aware of the incident should have notified the RPN or Nurse Manager immediately instead of waiting for the RPN to return from their break. The ED further indicated these team members, as well as the RPN, did not comply with the home's policy and caused an unnecessary delay in providing immediate protection and support for the victimized resident.

Failing to follow the home's policy to prevent abuse and neglect put a resident at risk for possible additional abuse and feelings of despair.

Sources: The home's policy titled the Prevention of Abuse & Neglect of a Resident,

VII-G-10.00 last revised October 2023, the home's investigation notes and interviews with the ED and other staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Ensure resident #001 is protected from abuse.

Grounds
The licensee has failed to ensure resident #001 was protected from abuse by resident #002.

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A team member observed resident #002 inappropriately touching resident #001 in their room. When confronted resident #002 immediately left. Video surveillance from resident #001's room, as well as hallway surveillance, verified this occurred several times. Resident #002 was arrested by the police, was charged with a

criminal offence and no longer resided in the home.

The ED confirmed the home did not protect resident #001 from abuse by resident #002.

The risk of harm was severe as the home did not protect resident #001 against the repeated abuse by resident #002.

Sources: Resident #001 and #002's clinical records including progress notes and care plans, the home's investigation notes, video footage, and interviews staff and a police detective.

This order must be complied with by November 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

A CO was issued related to LTCHA, 2007, s. 19 (1) Duty to protect on November 16, 2021, as part of inspection #2021-938758-0002.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)
Duty to protect
s. 19 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

Develop an in-depth analysis of the home's response to reported incidents of resident #002's inappropriate responsive behaviours that occurred in 2021.

This analysis should include:
1. What action the home took
2. What action the home could have taken but did not
3. How the cognitive status of the victims impacted the response of the home and the authorities
4. Research into when a victim with dementia is to most likely to recall events

A record of this analysis must be kept and provided to the inspector upon request.

Grounds
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 24 (1) of the FLTCA.

A) The licensee has failed to ensure resident #004 was protected from abuse by resident #002.

Rationale and Summary
Section 2 of the Ontario Regulation 79/10 defined sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation

directed towards a resident by a person other than a licensee or staff member."

A team member observed resident #002 inappropriately touching resident #004. This was verified by the home's hallway video surveillance. The police were contacted and gave resident #002 a verbal warning not to touch other residents. The ED confirmed that the home did not protect resident #004 from abuse by resident #002.

There was risk to resident #004's dignity as resident #002 inappropriately touched them.

Sources: A Critical Incident (CI), the home's investigation notes, progress notes for resident #002 and #004, video surveillance footage and an interview with the ED.

B) The licensee has failed to ensure resident #005 was protected from abuse by resident #002.

Rationale and Summary
Resident #005 told a team member that resident #002 touched them inappropriately. Other team members who spoke with resident #005 validated the allegation. Afterwards, resident #005 refused to speak with the police.

The ED indicated they believed resident #002 abused resident #005.

There was a risk to resident #005's emotional well-being as resident #002 inappropriately touched them.

Sources: A CI, resident #005's progress notes, the home's investigation notes and interviews with team members and the ED.

C) The licensee has failed to ensure resident #006 was protected from abuse by resident #002.

Rationale and Summary
A team member observed resident #002 was in close proximity to resident #006. Resident #006 stated resident #002 had inappropriately touched them. Another team member responded and received the same statement from resident #006. Video surveillance revealed that resident #002 entered resident #006's room at the time of the above incident. When the police arrived later the same day, resident #006 did not recall the incident.

The ED confirmed that the home did not protect resident #006 from abuse by resident #002.

There was a risk to resident #006's emotional well-being as resident #002 inappropriately touched them.

Sources: A CI, resident #006's progress notes, the home's investigation notes and interviews with team members and the ED.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #003 Responsive behaviours

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are

developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Retrain all direct care staff that were on the unit where events occurred and who are currently still in the home of the importance of resident monitoring and reporting of responsive behaviours.

This retraining should include a case study of resident #002's behaviours.

A record must be kept including the dates of the education, content and who provided and participated in the retraining.

Grounds
The licensee has failed to ensure that monitoring and internal reporting protocols were followed for resident #002 with responsive behaviours.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure monitoring and internal reporting protocols are developed to meet the needs of residents with responsive behaviours.

Specifically, staff did not comply with home's policy that indicated Personal Support Workers (PSWs) will monitor and notify the nurse if any activities of daily living (ADLs) trigger responsive behaviours.

Rationale and Summary
Resident #002 inappropriately touched resident #001. There were previous

reported similar incidents. There had been no recent incidents reported or documented. During the home's investigation, it was identified that resident #002 had touched a PSW inappropriately when assisting with an ADL. The PSW indicated that they thought this was normal for resident #002 and therefore did not report it to anyone. The Director of Care (DOC) confirmed this PSW did not follow the home's expectation to document and report such behaviours and indicated the staff had normalized resident #002's behaviour.

Previously, team members described resident #002 as behaving in certain ways on the unit. The DOC stated that when they reviewed the hallway surveillance, they noticed these behaviours. Also, during fact finding interviews, a PSW indicated they thought resident #002 had such behaviours. Both the DOC and ED stated the staff should have reported this behaviour as this would have alerted them that the resident's previous behaviour was still evident.

Failing to report responsive behaviours prevented the home from implementing additional interventions to decrease the risk of resident #002 abusing others.

Sources: The home's policy titled Responsive Behaviours Management, VII-F-10.10 revised in November 2022 and still in effect June 2024, the home's investigation notes, resident #002's progress notes, and interviews with a PSW, the DOC and ED.

This order must be complied with by January 31, 2025

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.