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: November 21, 2023

Inspection Number: 2023-1317-0004

Inspection Type:
Complaint
Critical Incident
Follow up

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

Long Term Care Home and City: Harmony Hills Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2023.11.22 09:47:32 -05'00'

Additional Inspector(s)
Cindy Ma (000711)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7-10, 14-16, 2023

The following intake(s) were inspected:

- Intake: #00090393 - [Critical Incident (CI): 2832-000009-23] - Resident to resident physical abuse
- Intake: #00098606 - Follow-up related to transferring and positioning
- Intake: #00099198 - Complaint related to plan of care
- Intake: #00099614 - [CI: 2832-000015-23] - Fall with injury
- Intake: #00100957 - [CI: 2832-000016-23] - Infection prevention and control

The following intake(s) were completed in this inspection: Intake: #00090123 - [CI: 2832-000007-23], and Intake: #00093775 - [CI: 2832-000012-23] were related to fall with injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1317-0003 related to O. Reg. 246/22, s. 40 inspected by Henry Chong (740836)

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #003 was protected from physical abuse.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
On an identified date, a Critical incident (CI) was reported to the Director related to an incident of resident-to-resident physical abuse.

Review of clinical records indicated that resident #002 and resident #003 were involved in a physical altercation. As a result, resident #003 sustained an injury. This was also confirmed during interviews with Personal Support Worker (PSW) #108 and Registered Practical Nurse (RPN) #109.

Director of Care (DOC) verified the above mentioned incident constituted physical abuse.

There was physical impact to resident #003 when they were physically abused by resident #002.

Sources: Resident's clinical records; Critical incident report #2832-000009-23; and interviews DOC and other staff.

[000711]

WRITTEN NOTIFICATION: Reporting critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary
On an identified date, a critical incident report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023 indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

ADOC #106 confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Sources: Critical Incident Report 2832-000016-23; MLTC Reporting Requirements - reference sheet; and interview with ADOC #106.

[740836]