Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 19, 2021	2021_642698_0008	003379-20, 004846-20, 006738-20, 006753-20, 010058-20, 013508-20, 017690-20, 018240-20	Critical Incident System

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street North York ON M2K 1E1

Long-Term Care Home/Foyer de soins de longue durée

Seniors' Health Centre
2 Buchan Court North York ON M2J 5A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 8, 9, 12-16, 19-23 and 26-28, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
CIS/Log #2744-000012-20/003379-20, #2744-000014-20/004846-20, #2744-000020-20/010058-20, #2744-000021-20/013508-20, #2744-000027-20/017690-20, #2744-000029-20/018240-20 related to falls; #2744-000015-20/006738-20, #2744-000016-20/006753-20 related to responsive behaviours,

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) observed staff to resident and resident to resident interactions, provision of care, conducted record reviews of residents' health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to protect residents #006 and 007 from physical abuse by anyone.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Resident #005 experienced responsive behaviours resulting in altercations with resident #006 and #007 causing injuries to both residents.

Review of resident #005's clinical records indicated that an intervention for responsive behaviors was not implemented as indicated in the care plan.

Interventions to prevent physical abuse to residents #006 and #007 were ineffective.

Sources: resident #005, #006 and #007’s electronic records, CIS reports, abuse POLICY #VII-G-10.00 and staff interviews. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were provided as specified in the plan.

Review of the resident's clinical records indicated that an intervention for injury prevention was not implemented as indicated in the care plan.

The resident's care plan indicated that staff should apply a bed safety device when the resident was in bed. Staff reported that there had not been a bed safety device as indicated in the plan of care for approximately 12 months.

The staff failed to provide care to the resident when the plan of care was not followed as specified in the resident’s care plan.

Sources: observations, staff interviews, electronic record and POLICY #: VII-G-30.10 reviews. [s. 6. (7)]

Issued on this 15th day of June, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.