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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date May 26, 2022
Inspection Number 2022_1238_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

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

Long-Term Care Home and City
Seniors' Health Centre
2 Buchan Court North York ON M2J 5A3

Inspector who Amended
Ivy Lam (646)

Inspector Digital Signature
Ivy Lam
2022.05.26 15:47:59 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This inspection report has been revised to reflect a correction in the Report Issue Date. The Complaint and Critical Incident System inspection #2022_1238_0001 was completed on May 20, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25-29, and May 2, 2022.

The following intake(s) were inspected:

- Intake #002920-22: (CIS # 2744-000004-22) related to care and services, and hospitalization.

- Intake #020996-21 (Complaint) related to allegations of neglect, nutrition and hydration care, falls prevention, weight changes, menu planning, and dealing with complaints.

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- Intake # 021081-21 (Complaint) related to allegations of neglect, skin and wound care for the resident, care and services, nutrition and diabetes management, and resident's significant weight change.

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s.6(10)(b)

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Rationale and Summary
According to the plan of care, resident #002 was to wear a falls prevention intervention.

Observation of resident #002 over three days showed the resident was not wearing the falls prevention intervention. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated the resident had not been using the intervention since their return from the hospital.

The RPN and the Registered Nurse (RN) indicated the resident's care plan needed to be updated, since the item was no longer a part of resident's falls prevention care and the resident no longer required it.

The Assistant Director of Care (ADOC) indicated that the care plan should have been updated when the resident no longer required the falls prevention intervention. The ADOC indicated they would update resident #002's care plan and remove the intervention.

The resident's care plan was updated on April 29, 2022, and the intervention was removed.

Sources: Resident #002's care plan with revision history, resident's updated care plan on April 29, 2022, observations of resident and resident and staff interactions; interviews with Personal Support Worker (PSW) #113, Registered Practical Nurse (RPN) #114, Registered Nurse (RN) #115, and Assistant Director of Care (ADOC) #106.

Date Remedy Implemented: April 29, 2022 [646]

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WRITTEN NOTIFICATION: PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s.* 6(4)(a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the assessment of the chronic health condition so that their assessments were integrated and were consistent with, and complemented each other.

Rationale and Summary
Resident #001 had a chronic health condition. Registered staff were to monitor for the condition, but no specific parameters of monitoring were identified.

The resident experienced an episode related to their chronic health condition. The physician was notified, and new medication was ordered, and another medication was adjusted to address the condition.

Monitoring was ordered for another seven days, the physician (MD) to reassess at the end of the seven days. The MD's progress notes seven days later did not indicate a review of the resident's specific chronic health condition, and no further direction for monitoring was provided

Resident #001's was monitored for the chronic health condition for another seven days, where an RN documented a second episode related to their chronic health condition. However, no documentation was identified related to follow up actions or endorsement to next shifts. No assessment or monitoring of the resident's chronic health condition was documented for the resident for 43 days.

On the 44th day, resident #001 had a third episode related to their chronic health condition.

The RN indicated they should have continued monitoring the resident's chronic health condition after the second episode, and should have notified the MD. Another RN indicated that a discussion with the MD should be done to clarify the frequency of monitoring.

The MD indicated that they would expect the staff to call and to continue to monitor the resident after the second incident, but that it was not brought to the MD's attention at the time.

The ADOC indicated the registered staff should have notified the MD after the second episode, but there was no written direction to clearly direct the staff on how to monitor the resident. There was no monitoring or assessment done regarding the resident's chronic health condition after their second episode for 43 days, until the resident experienced a third episode related to their chronic health condition.

When staff involved in resident #001's care do not collaborate with each other in the monitoring and assessment of the resident's chronic health condition, there is a risk of delayed treatment provided to manage the resident's health and an increased risk of negative health outcomes.

Sources: Resident #001's care plan, progress notes, eMAR, Physician order forms; Interviews with RN #103, Charge RN #100, Physician (MD) #104, and ADOC #106. [646]

WRITTEN NOTIFICATION: COMMUNICATION METHODS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 43.

The licensee has failed to ensure that strategies were developed and implemented to meet the needs of resident #002 who could not communicate in the language or languages used in the home.

Rationale and Summary

Resident #002's did not speak English, and was described as outgoing and extroverted on their admission assessment.

The resident exhibited responsive verbal and physical behaviours after admission.

Review of the health record indicated that the registered staff, pharmacy consultant and the outreach team identified language barriers as a cause for resident #002's responsive behaviours.

Recommendations to address the resident's behaviours included having team members who spoke the resident's language to be involved in the resident's care, if available, and scheduling social calls with the resident's family member as a social event or opportunity, and not waiting until a responsive behaviour occurs. Other interventions were also recommended but PSWs and registered staff indicated these interventions were not effective when the resident had responsive behaviours.

The RPN indicated the most effective strategy to address the resident's responsive behaviours was to have the resident's family member or a team member who spoke the resident's language to translate for the resident.

The RN indicated they were not aware of staff translators on the shift when the resident exhibited their responsive behaviours more frequently

The ADOC/Behaviours Co-lead indicated resident #002 appeared confused with video chats, and family was not consistently available for social calls.

The Activities Coordinator/Behaviours Co-lead, ADOC, and the Executive Director (ED) indicated additional work should be done to meet the resident's communication needs and language barriers, including staff awareness of which staff can translate for resident #002, and arranging for staff who spoke to the resident's language for a social visit with the resident. They further indicated these interventions may not be available for the resident during the shift when the resident's responsive behaviour happened most frequently.

When effective strategies were not developed to meet the needs of resident #002's, there is a risk that the resident's social needs would not be met, and further contribute to the resident's responsive behaviours

Sources: Resident #002's Leisure and Well-being – Move-In Assessment, care plan, progress notes, Behaviour Support Plan – Behavioural Support Services Mobile Support Team, Geriatric Mental Health Outreach progress notes, Pharmacy Consultation progress notes, resident's eMAR; Observations of resident #001's interaction with staff and co-residents; Interviews with RPN #114, RN #115, ADOC/Behaviours Co-lead #107 Activities Coordinator/Behaviours Co-lead #105, ADOC #106, the Executive Director (ED), and other staff. [646]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.50(2)(b)(iv)

The licensee has failed to ensure that resident #001, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
The home's skin and wound policy indicated that a nurse would conduct an admission skin assessment. For a resident exhibiting altered skin integrity, the nurse would also complete weekly electronic skin and wound assessments until the skin alteration was closed or healed.

Resident #001 was admitted with altered skin integrity in one area of their body, and an initial skin assessment was done on admission. The weekly skin assessment was not completed on two weeks after admission and resumed on the third week after admission. The resident developed a second altered skin integrity on another area of their body, and weekly skin assessments were ordered. Review of the weekly skin assessments showed one week where weekly skin assessment was not completed for both altered skin conditions.

The RPN who completed the initial skin assessment on admission indicated that the weekly skin assessment follow up was not ordered or completed until the third week after the resident was admitted. The ADOC responsible for completing the assessments indicated that a weekly assessment was missed for both wounds. The RN and the ADOC further indicated that weekly skin assessments should have been done for resident #001 to monitor the altered skin integrity

and should have continued until the altered skin integrity were healed. They indicated that the weekly skin assessments were missed on the dates mentioned above.

When resident #001's two areas of altered skin integrity were not reassessed at least weekly, there was a risk that appropriate wound care interventions would not be provided to the resident based on their wound condition and put the resident at increased risk of negative health outcomes.

Sources: Resident #001's wound evaluations, progress notes, eMAR, Home's policy Skin & Wound Care Management Protocol – Skin & Wound App #VII-G-10.92; interviews with RPN #111, RN #100, and ADOC #107/Skin and Wound lead. [646]

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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.