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

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Amended Public Report (A1)

Report Issue Date September 14, 2022
Inspection Number 2022_1238_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
North York General Hospital

Long-Term Care Home and City
Seniors' Health Centre, North York

Inspector who Amended
Julie Ann Hing (#649)

Additional Inspector(s)
Kehinde Sangill (#641740)

Inspector who Amended Digital Signature
Julie ann Hing
Digitally signed by Julie ann Hing
Date: 2022.09.15 16:40:52 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This inspection report has been revised to reflect the correct inspection number. The Critical Incident System and Complaint inspection was completed on September 1, 2, 6, 7, 8, 9, and off-site on 12, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1, 2, 6, 7, 8, 9, and off-site on 12, 2022.

The following intake(s) were inspected:

- Intake #010442-22 (CIS #2744-000142-22) related to Prevention of Abuse and Neglect
- Intake #010435-22 (Complaint) related to Residents' Bill of Rights
- Intakes #018276-21 (CIS #2744-000034-21), #016649-21 (CIS #2744-000032-21), #014608-22 (CIS #2744-000172-22), #015899-21 (CIS #2744-000030-21), and #007115-21 (CIS #2744-000009-21) related to fall prevention and management.

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

- Falls Prevention and Management

- Infection Prevention and Control (IPAC)
- Residents' Rights and Choices
- Responsive Behaviours

INSPECTION RESULTS

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. 3 (1) 11.

The licensee has failed to ensure that every resident has the right to live in a safe and clean environment.

Rationale and Summary:
A co-resident had gone into another resident's room and had an interaction without any injuries.

Record review and staff interviews indicated several reports that one of the residents expressed feeling scared of the co-resident who had gone into their room after the incident had occurred.

The co-resident was moved to a different area. Staff reported that the resident had not made any recent remarks of being scared of the co-resident, even though they have seen them on the home area.

Sources: Observations of two residents, review of two resident's clinical record, review of Critical Incident System (CIS) report #2744-000142-22, interview with Registered Practical Nurse (RPN) and other relevant staff.

Date Remedy Implemented: June 15, 2022 [#649]

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. (6) (10) (b)

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

Rationale and Summary:

A resident was observed in their mobility aide without a device. Personal Support Worker (PSW) found the device and immediately applied it to the resident.

According to the resident's care plan, it indicated use of two other different devices.

The RPN advised that the resident had been using the device for the last couple of years as the other device was not preferred by the resident. They explained that the resident requires the device as they would try to perform activities of daily living without staff assistance. They were unsure why the resident's plan of care had not been updated and revised with the current device.

Failure to update and revise the resident's plan of care put them at risk of not having the correct intervention monitored by staff.

Sources:
Several observations of the resident, review of the resident's clinical record, review of CIS report #2744-000034-21, interview with RPN, and other relevant staff. [#649]

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident.

Rationale and Summary:
A resident sustained a fall that resulted in an injury while they used a device. The device was identified as a contributing factor to the resident's fall. The resident's family member requested that they only use the device for specific purposes.

The inspector observed the resident using this device on two separate occasions.

The resident's care plan indicated use of another type of device to reduce the risk of falls.

The Registered Nurse (RN) acknowledged that the resident was using the device when they fell. Several staff told the inspector that the resident's use of the device observed on the above two occasions was not appropriate.

The failure of staff to ensure use of appropriate device for the resident put them at risk of another fall-related injury.

Sources: Observations of the resident, review of the resident's clinical record, CIS report #2744-000032-21, interviews with PSWs, RPN and RN. [#741670]