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

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Original Public Report

Report Issue Date: January 31, 2023	
Inspection Number: 2023-1238-0006	
Inspection Type: Critical Incident System	
Licensee: North York General Hospital	
Long Term Care Home and City: Seniors' Health Centre, North York	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature** Henry A Chong Digitally signed by Henry A Chong Date: 2023.02.02 13:23:25 -05'00'
Additional Inspector(s) Christine Francis (740880)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 24-27, 2023

The following intake(s) were inspected:

- Intake: #00001386 Fracture etiology unknown
- Intake: #00002643 Resident to resident physical abuse
- Intake: #00003379 Fracture etiology unknown
- Intake: #00003536 Fracture etiology unknown

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

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

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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee failed to ensure that point-of care signage indicating that enhanced IPAC control measures are in place, as required by Additional Precautions 9.1 (e) under the IPAC standard.

On an identified date, a staff member was observed entering a resident's room on precautions. A precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff, including an N95 mask. The staff member wore a surgical mask, gloves, gown, and face shield prior to entering the room, but did not wear an N95 mask.

The Infection Control Practitioner (ICP) stated that the resident was on precautions at the time of the observation. The ICP said that staff entering the resident's room should be wearing gowns, gloves, surgical mask, and eye protection and that wearing an N95 mask is a recommendation. The ICP confirmed that the precautions sign was incorrect and had been updated to indicate the correct PPE to be worn by staff. The signage was subsequently removed when the resident was no longer on isolation.

The precautions sign was no longer observed on the following day.

Sources: Observations, and interviews with Infection Control Practitioner (ICP).

[740836]

Date Remedy Implemented: January 25, 2023

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 (1) 5.

The licensee has failed to ensure that a disease outbreak was immediately reported to the director.

Rationale and Summary
On an identified date, a disease outbreak was declared on a floor. The outbreak was declared on an additional floor several days later. The home reported the incident to the Director several days after the initial outbreak. The Director of Care stated that the outbreak was not reported immediately.

Sources: CIS report 2744-000002-23, and interview with Director of Care.

[740836]

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 #002 is protected from physical abuse by resident #001.

Section 2 (1) of the Ontario Regulation 246/22 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, resident #001 and resident #002 were involved in a physical altercation when resident #001 was in front of resident #002’s room. The residents were discovered by staff and noted that they had an interaction with each other and as a result of the interaction, both residents sustained an injury.

The Director of Care said that physical abuse occurred as there was injury to the residents.

Sources: CIS report 2744-000119-22, resident #001 and resident #002's clinical records, and interviews with Director of Care and other staff.

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