Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 25, 2023
Original Report Issue Date: May 1, 2023
Inspection Number: 2023-1238-0007 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: North York General Hospital
Long Term Care Home and City: Seniors' Health Centre, North York

Amended By	**Inspector who Amended Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.05.25 15:34:49 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been revised to reflect the new compliance due date for CO #001 to June 30, 2023. The inspection #2023-1238-0007 was completed on April 4- 6, 11-14, 17-19, and 27, 2023.

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Licensee: North York General Hospital	
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Lead Inspector Rajwinder Sehgal (741673)	**Additional Inspector(s)** Adelfa Robles (723)
Amended By Rajwinder Sehgal (741673)	**Inspector who Amended Digital Signature** Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.05.25 15:35:16 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been revised to reflect the new compliance due date for CO #001 to June 30, 2023. The inspection #2023-1238-0007 was completed on April 4- 6, 11-14, 17-19, and 27, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 5, 6, 11, 12, 13, 14, 17, 18, 19, 2023.

The inspection occurred off-site on the following date(s): April 27, 2023.

The following intakes were inspected in this complaint inspection:

- Intake: #00016739 related to privacy breach of a resident.
- Intake: #00021482 related to multiple concerns pertaining to a resident's care and operation of the long-term care.
- Intake: #00085330 related to doors in the home.

The following intakes were inspected in the Critical Incident System Inspection:

- Intake: #00004052 - [CI: 2744-000181-22/CI: 2744-000182-22] related to unexpected death of a resident
- Intake: #00007930 - [CI: 2744-000191-22] related to potential physical abuse from staff member towards the resident.
- Intake: #00017723 – [CI: 2744-000001-2] related to potential physical abuse from staff member towards the resident.
- Intake: #00084541 – [CI:2744-000009-23] related to falls.
- Intake: #00002170 – [AH: IL-03378-AH/CI: 2744-000167-22] related to responsive behaviour.

The following intake(s) were completed in the Critical Incident System Inspection:

- Intake: #00006130 - [CI: 2744-000189-22] related to falls.
- Intake: #00006649 - [CI: 2744-000116-22] related to falls.
- Intake: #00015654 - [IL-08142-AH/2744-000204-22] related to falls.
- Intake: #00016997- [CI: 2744-000206-22] related to falls.
- Intake: #00021701 - [IL-10642-AH/2744-000005-23] related to unexpected death of a resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

AMENDED 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. 12 (1) 3.

The licensee has failed to ensure that a door leading to non-residential areas was equipped with a lock to restrict unsupervised access to those areas by residents, and to ensure the door must be kept closed and locked when it was not being supervised by staff.

Rationale and Summary:
A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding a door leading to non-residential area on the floor was not equipped with a lock.

During three different observations, the oxygen cylinder storage room on the first-floor resident home area (RHA) was found to be unlocked and not equipped with a functioning lock.

There were no residents in the vicinity at the time of the observations.

The staff indicated that the door had been without a lock and were not sure how long the lock was broken. They confirmed the room is used as a storage room and should be locked at all times.

On April 19, 2023, the oxygen room door was locked and equipped with a lock.

Sources: Observations on three identified days, interviews with RPNs, and EM.

Date Remedy Implemented: April 19, 2023

[741673]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their policy to promote zero tolerance of abuse and neglect was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that their policy on resident abuse and neglect include emotional support and provision of internal resources, including ensuring a Social Service Worker (SSW) was made available. O. Reg 246/22 s. 103 (b) required that under section 25 of the Act to promote zero tolerance of abuse and neglect of residents contains interventions to deal with persons who have been abused or allegedly abused.

Specifically, the staff did not comply with the policy Prevention of Abuse & Neglect when a SSW referral was not submitted for a resident.

Rationale and Summary
The home submitted a Critical Incident (CI) report related to an alleged staff to resident physical abuse.

The home's policy indicated that support and/or counselling will be offered to all victims of alleged abuse/neglect and emotional support including making the SSW as available.

The resident's progress notes at the time of incident indicated that the resident developed further changes to their responsive behaviours. There was no SSW referral submitted for the resident prior to and after the incident.

The staff member stated that as per the home's policy, a SSW referral was expected to be completed after an alleged staff to the resident physical abuse. They acknowledged that they missed to submit a SSW referral for the resident.

SSW stated that after an alleged staff to the resident abuse, a SSW referral was part of the whole referral process. SSW also stated that providing support and knowing that somebody was there for the resident at the time of incident would have been helpful.

Failure of the home to utilize the SSW for the resident increased their risk for unmet social and emotional needs.

Sources: Resident's written Plan of Care, progress notes, Scarborough Health Network (SHN) Hospital Notes, interviews with SSW, RPNs, and ADOC.

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessment of the diet and fluid texture so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
The home submitted a CI report related to an unexpected death of the resident. Prior to this incident, the resident had a change in their condition after an injury from an incident.

Review of the home's policies indicated that nurses are to complete a dietary referral upon readmission from hospital, new diagnoses and when a resident was identified and recognized with chewing and swallowing difficulties.

The resident records indicated that they had identified concerns with their meals. The last Registered Dietitian (RD) referral was completed on a previously an identified date, long before these new concerns arouse.

The staff stated that the resident gradually declined.

After the resident’s incident, they required further assistance and had further identified concerns with their meals. Both registered staff acknowledged that an RD referral was missed when the resident was observed with difficulty with their meal.

Assistant Director of Care (ADOC) stated that staff were expected to send an RD referral upon resident’s readmission from the hospital and when changes were observed related to their meal intake. The home's RD stated that when staff created interventions to address the resident’s dietary concerns, an assessment from the RD was also required for resident’s safety.

Failure of the home to collaborate to staff involved in the resident’s different aspects of care increased the risk for errors, delayed treatment, and increased risk of negative health outcomes.

Sources: CIS report, home’s policies on Management of Dysphagia & Choking Risks, VII-I-10.80, last revised 05/2021; referral to dietitian and/or Director of Dietary Services, VIIID-10.10 last revised 11/2019, resident's IPDR dated August 28, 2022, Progress Notes, RAI-MDS Annual Assessment, Written

Plan of Care, interviews with PSWs, RPNs, ADOC and RD.

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 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 a resident was reassessed and the plan of care reviewed and revised when their care needs changed.

Rationale and Summary
The home submitted a CI report when the resident fell and returned from the hospital with a new diagnosis. Hospital discharge instructions included the application of a device.

The resident's written plan of care did not include the use of the device as a new intervention. The staff acknowledged that the resident's written plan of care was not updated to include the new intervention post hospitalization. ADOC #108 also stated that staff were expected to update the resident's plan of care to reflect the resident's care needs.

Failure to include new interventions related to the resident's current care needs put them at potential risk of not receiving their care requirements and/or improper use of their new interventions.

Sources: Resident's written Plan of Care, progress notes, Scarborough Health Network (SHN) Hospital Notes, interviews with RPNs and ADOC.

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure the provision of the care set out in the plan of care was documented for a resident participation in recreation programming.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) that the home was not assisting

and supporting the resident to participate in programs of interest.

The resident's ActivityPro report indicated that there were several days of missed documentation for a period of months.

The home's policy titled "Individual Leisure Pursuits" directed activation staff to document all independent activities that residents participate in or have expressed interest in the care plan and capture in attendance records.

Activation Aide (AA) acknowledged that they attempted invite the resident to programs, however, these attempts were not consistently documented under ActivityPro.

Activities Coordinator (AC) acknowledged that AAs are expected to document each time the resident is invited to programs and the reason for the absence through ActivityPro.

Sources: Resident's clinical records, resident's ActivityPro report, the home's policy titled "Individual Leisure Pursuits" X-E-10.20 last revised date of March 2019, and interviews with AA, AC and other staff.

[741673]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that they had immediately forwarded to the Director any written complaint that it received concerning the care of a resident where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding the home not responding to the resident's Substitute Decision Maker (SDM) complaints concerning the resident's care.

The home's April 2023 complaints record indicated that a number of complaints were submitted by the resident's Substitute Decision Maker (SDM) concerning the care of the resident.

The home's policy titled "Complaints Management Program (ON)" directed to inform the MLTC Critical Incident and Triage Team (CIATT) of all written complaints as per Ministry regulations.

Executive Director (ED) acknowledged that written complaints were not reported to the MLTC. The critical incident system portal indicated that no critical incidents had been submitted related to written complaints in April 2023.

Sources: Review of Critical Incident System portal, home's complaints record for April 2023, review of Complaints Management Program (ON), XXIII-E-10.00, last revised on August 2022, and interview with ED.

[741673]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure that the results of investigations undertaken for alleged, suspected, witnessed, or reported incidents of abuse/neglect of resident #005 and resident #004 were reported to the Director.

Rationale and Summary
The home submitted a CI report related to an alleged resident to resident physical abuse between residents #004 and #005.

The home completed their investigation but did not report the outcome of the investigation to the Director. ADOC stated that the incident was investigated but the home missed to update the CI to the Director.

Failure of the home to notify the Director of the results of every investigation of reported incident of alleged abuse of resident #005 prevented the Director from responding as required.

Sources: CIS report, interviews with RPN and ADOC.

[723]

Rationale and Summary

The home submitted CI reports related to the resident's witnessed fall incident and unexpected death. The home completed their investigation but did not report the outcome of the home's investigation to the Director.

The staff member stated that as per the home's process, the ADOC or the Director of care (DOC) were to submit and amend CI reports submitted by the home. They confirmed that the home completed an investigation related to the incident. ADOC stated that the home missed to update the CI report to indicate the outcome of the investigations.

Failure of the home to notify the Director of the results of every investigation of reported incident of neglect for resident #002 prevented the Director from responding as required.

Sources: CIS report, Home's Investigation Notes, interviews with RPN and ADOC.

[723]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #001 and #007.

Rationale and Summary
1) The home submitted a CI report when resident #001 had an unwitnessed fall, sustained injuries, and complained of pain on specified areas.

Resident #001's incident form indicated that the resident sustained a fall and received a level of assistance from staff with their transfer following the fall. The home's investigation notes completed for resident #001 revealed that the resident was transferred with the level of assistance indicated on the incident form.

The staff member stated that when resident #001 fell, the registered staff was informed and transferred the resident with a level of assistance provided to them.

The ADOC indicated that the staff did not provide a safe transfer for the resident in accordance to what they were supposed to do after a resident sustains a fall.

There was an increased risk of injury to resident #001 when the staff failed to use the proper technique to safely assist the residents during transfers.

Sources: Home's investigation notes, resident #001's progress Notes, interviews with staff and ADOC.

[723]

Rationale and Summary
2) The Post Fall Assessment created on January 10, 2023 indicated that resident #007 fell on the floor and on assessment, the resident was already transferred. The resident's written plan of care indicated that the resident required a specific type of transfer.

The staff stated that it was an expectation to use a specified transfer technique after the resident sustains a fall.

ADOC #107 stated that based on the home's investigation including review of camera footage, PSW #118 did not follow the proper transfer technique after the resident sustained a fall.

There was an increased risk of injury to resident #007 when staff failed to use safe transfers and positioning techniques when assisting residents.

Sources: Home's investigation Notes for resident #007 dated January 6-10, 2023, resident #007's written Plan of Care, Progress Notes, interviews with staff, ADOC and DOC.

[723]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that when a resident sustained an altered skin integrity, they were assessed at least weekly by a member of the registered staff.

Rationale and Summary
The home's policy indicated that for a resident exhibiting altered skin integrity including skin tears or wounds, registered staff were directed to complete an electronic weekly skin and wound assessment.

The Head-to-Toe Assessment was to be completed by registered staff for residents who experienced skin alterations including bruising.

The home submitted a CI report for an alleged staff to the resident physical abuse. As a result of the incident, the resident had a fall and sustained skin injuries.

The resident's progress notes indicated that their injuries were assessed on identified dates. There were no other weekly skin and wound assessments completed until their wounds were resolved.

The staff member acknowledged that weekly skin and wound assessments were missed for a number of weeks. ADOC acknowledged that weekly skin and wound assessments for the resident should had been completed weekly until it was healed.

There was a risk for delayed treatment and healing for the resident when their wound did not receive weekly assessment.

Sources: Home's policy on Skin & Wound Care Management Protocol, VII-G-10.90 last revised 04/2023, home's investigation notes, resident's progress notes, completed Head to Toe, Skin & Wound Assessments, interviews with RPN and, ADOC.

[723]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A complaint was submitted to the MLTC regarding the home not responding to the resident's Substitute Decision Maker (SDM) complaints concerning care.

The home's April 2023 complaints record indicated that a number of complaints were submitted to the home by the resident's Substitute Decision Maker (SDM) concerning the care of the resident.

A review of the licensee's responses to the complainant did not include the Ministry's toll-free number for making complaints and its hours of service, and the contact information for the Patient Ombudsman.

The home's policy titled "Complaints Management Program (ON)" directed for written complaints to include in the response the Ministry's toll-free number for making complaints and its hours of service, and the contact information for the Patient Ombudsman.

The ED acknowledged that responses provided to the complainant related to the resident's care concerns did not include information about the Ministry's toll-free number for making complaints and its hours of service, and the contact information for the Patient Ombudsman.

Sources: Home's complaints record for April 2023, review of Complaints Management Program (ON), XXIII-E-10.00, last revised on August 2022, interviews with ED and DOC.

[741673]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that the response provided to a person who made a complaint included if the licensee was required to immediately forward the complaint to the Director and a confirmation that the licensee did so.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding the home not responding to the resident's Substitute Decision Maker (SDM) complaints regarding the resident's care.

The home's April 2023 complaints record indicated that a number of complaints were submitted to the home by the resident's Substitute Decision Maker (SDM) concerning the care of the resident. The licensee's responses to the complainant did not specify whether the complaints were required to be reported to the Director and if so confirmation that they were reported.

The home's policy titled "Complaints Management Program (ON)" directed for written complaints to include in the response whether the complaint is required to be reported to the Director and if so confirmation that it was reported.

The ED acknowledged that responses provided to the complainant related to the resident's care concerns did not include information on the home's requirement to report it to the Director. DOC stated that these requirements were only included in responses when the complaint was submitted to the Director.

Sources: Home's complaints record for April 2023, review of Complaints Management Program (ON), XXIII-E-10.00, last revised on August 2022, interviews with DOC and ED.

[741673]

COMPLIANCE ORDER CO #001 PREVENTION OF ABUSE AND NEGLECT

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2022, s. 24 (1).

Specifically, the licensee must:
1. Review the contents of the compliance order with all the staff in the home.
2. Re-educate all staff related to the home's policy on Prevention of Abuse & Neglect of Residents and Resident's Bill of Rights.
3. Document the education provided, including the content of the material reviewed, the date completed, and the staff member who provided the education.

Grounds
The licensee has failed to ensure that resident #007 was protected from physical abuse by a staff.

Section 2 of the Ontario Regulations 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
The home submitted a CI report related to an alleged physical abuse from a staff member to resident #007.

Resident #007's progress notes indicated that a staff member provided inappropriate care to the resident leading to a fall. After the incident, the resident complained of pain, sustained injuries and

required additional interventions. The same information was indicated in the home's investigation notes.

Another staff stated that the resident was upset and told them that staff member provided inappropriate care hence, they ended up on the floor. ADOC and the DOC both stated that staff member was disciplined following the investigation of the incident.

There was actual harm to resident #007 when they were not protected from physical abuse by the staff member.

Sources: Home's policy on Prevention of Abuse & Neglect of a Resident, VII-G-10.00 last revised 10/2022, home's investigation Notes, resident #007's progress Notes, incident Report, interviews with staff.

[723]

This order must be complied with by June 30, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.