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

Toronto District
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Original Public Report

Report Issue Date: July 26, 2023

Inspection Number: 2023-1238-0008

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: North York General Hospital

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

Lead Inspector	**Inspector Digital Signature**
Maya Kuzmin (741674)	Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.07.28 16:54:31 -04'00'

Additional Inspector(s)
Ann McGregor (000704)
Ramesh Purushothaman (741150)

INSPECTION SUMMARY

The inspection occurred onsite and offsite on the following date(s): July 12-14 and 17-20, 2023

The following Critical Incident (CI) intake(s) were inspected:
- Intake #00086383 was related to a hypoglycemic episode of a resident
- Intake #00086644 and #00089423 was related to falls prevention and management

The following Compliance Order was reviewed:
- Intake: #00088467 Follow-up #: 1 - High Priority CO #001 / 2023-1238-0007, FLTCA, 2021 - s. 24 (1) Duty to Protect. CDD June 30, 2023.

The following Compliant intakes were inspected:
- Intake #00092027 was related to retaliation

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2023-1238-0007 related to FLTCA, 2021, s. 24 (1) inspected by Maya Kuzmin (741674)

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

Medication Management
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Safe and Secure Home
Prevention of Abuse and Neglect
Palliative Care
Falls Prevention and Management

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 doors leading to non-residential areas were kept closed and locked to restrict unsupervised access to those areas by residents, when they were not being supervised by staff.

Rationale and Summary:

On two separate occasions, a door leading to a non-residential area on the floors was open for several minutes without any staff supervision. Staff acknowledged that the doors were unlocked and then closed it. They confirmed that there were supplies stored in the room.

There were no residents in the vicinity at the time of both observations. Assistant to the Director of Care (ADOC) #120 and Administrator confirmed that the expectation was for the doors to any non-residential areas remain closed and locked to restrict unsupervised access by residents.

Sources: Observations, interviews with staff.

Date Remedy Implemented: July 18, 2023

[741150]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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

Rationale and Summary:

A Critical Incident (CI) was reported to the Director related to the use of medical treatment to treat a resident's specific medical condition.

A resident was provided with medical treatment for a specific medical condition. A staff documented that the resident had a change in condition. During this period, the resident was still administered medical treatment, despite their change in condition.

According to the home's policy, staff were supposed to monitor a resident's status and recognize symptoms of a specific medical condition. A staff documented that the resident had a change in condition, however, they did not communicate with the team. On an identified date, the resident demonstrated this change in condition, and a staff administered medical treatment despite the resident's observed change in condition. ADOC #120 acknowledged that there was an increased risk of harm to the resident when team members failed to communicate and collaborate their assessment findings.

The lack of integration of assessment by the team members put the resident at harm when medical treatments were not adjusted to the resident's change in condition.

Sources: Critical Incident, High-Alert Medication policy, III-4-2 (revised September 2019), resident's clinical records, interview with staff.

[000704]

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 a resident's plan of care related to several fall prevention interventions.

(a) Rationale and Summary:

A resident was identified as a high risk for falls with a intervention to be in place as per the plan of care. On an identified date, the resident fell and was transferred out to hospital for further assessment. The resident returned to the long-term care home (LTCH) with an injury.

At the time of the critical incident, the intervention was not in place. ADOC #109 acknowledged that the nursing team did not follow the policy as they did not communicate or follow the plan of care during this time for the resident.

Failure to complete the intervention by the staff placed the resident at risk for falls and potential injury.

Sources: Falls Prevention and Management Policy, VII-G-30.10 (revised April 2023); resident's clinical records; and interviews with staff.

(b) Rationale and Summary:

A resident's care plan indicated that they were encouraged to apply a fall prevention intervention. The resident was seen by the inspector without the specific intervention. A staff verified they were aware of the plan of care for the resident related to falls prevention and management and they forgot to apply the intervention. ADOC #109 acknowledged that staff did not follow the resident's plan of care.

There was an increased risk of falls to the resident as care plan related to falls prevention and management was not followed.

Sources: Observations; resident's care plan; interviews with staff.

[741674]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1)

The licensee has failed to ensure that training was provided to a staff who provided direct care to the resident related to falls prevention and management for the year of 2022.

Rationale and Summary:

A record review revealed that all direct care staff are to complete falls prevention and management program training. A staff failed to complete training modules for falls prevention and management program for the year of 2022. They indicated they would complete this training by a specified date. ADOC #109 acknowledged that direct care staff are to complete the training courses by Dec 31, 2022, and the particular staff did not complete such training for 2022.

There was an increased risk to residents as the staff may not have had complete knowledge of the falls prevention and management program.

Sources: Training Records 2022; interviews with staff.

[741674]