

### **Ministry of Long-Term Care**

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

#### **Toronto District**

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

## Original Public Report

Report Issue Date: January 23, 2024

Inspection Number: 2024-1238-0001 Inspection Type:

Licensee: North York General Hospital

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

Lead Inspector

**Inspector Digital Signature** 

Nrupal Patel (000755)

Critical Incident

### Additional Inspector(s)

Christine Francis (740880) and Julie Ann Hing (649) were present during this Inspection.

## **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 10-12, 16, 2024. The inspection occurred offsite on the following date(s): January 15, 2024.

The following intake(s) were inspected:

- Intakes #00099151 and #00103184 were related to falls prevention and management.
- Intake: #00099137 was related to a disease outbreak.



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

Infection Prevention and Control 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)

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

Plan of care

When reassessment, revision is required

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

## Rationale and Summary:



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A specific intervention was observed in resident's room as part of a falls prevention intervention. A review of the clinical records indicated that this specific intervention was not documented in the resident's care plan.

A Personal Support Worker (PSW) mentioned using a specific intervention for the resident when in bed. Upon reviewing the care plan, the Registered Nurse (RN) acknowledged that this specific intervention was not documented.

The resident's plan of care was promptly updated to include a specific intervention for falls prevention for the resident.

There was no risk identified when the resident's plan of care was not revised when the resident's care needs had changed.

Sources: Observations; resident's clinical records; interviews with PSW and RN.

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Date Remedy Implemented: January 12, 2024

## WRITTEN NOTIFICATION: Reports re 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.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under



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subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home has failed to ensure that the Director was immediately informed, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

#### **Rationale and Summary**

A COVID-19 outbreak was declared by the Public Health Unit (PHU) on several home areas. The Critical Incident System (CIS) report was submitted to the Director the following day.

The Director of Care (DOC) stated that the outbreak was not reported to the Director immediately.

There was a minimal risk associated with the delayed reporting, as interventions were promptly implemented.

Sources: Review of CIS #2744-000030-23; interview with DOC.

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