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

Original Public Report

Report Issue Date: June 28, 2024.

Inspection Number: 2024-1238-0002

Inspection Type:
Complaint
Critical Incident

Licensee: North York General Hospital

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

Lead Inspector	**Inspector Digital Signature**
Trudy Rojas-Silva (000759)	Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2024.07.03 09:46:28 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15-16, 23-24, 27-31, 2024, and June 5-7, and 10, 2024.

The following intake(s) were inspected:

- Intake #00111489 was related to fall prevention and management, responsive behaviors, preferred accommodation and, activation.
- Intakes #00106695/Critical Incident (CI) #2744-000001-24, #00111006/CI #2744-000004-24 and, #00111538/CI #2744-000005-24 were related to fall prevention and management.
- Intakes #00108184/CI #2744-000002-24, #00110624/CI #2744-000003-24, #00113340/CI #2744-000008-24/2744-000009-24 were related to the prevention of abuse and neglect.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for fall prevention and responsive behavior management was provided to the resident, as specified in the plan.

Rational and Summary

A complaint was lodged with the Ministry of Long-term Care related to a resident's plan of care interventions.

(i) Resident had specific fall prevention interventions written in their care plan.

Observations on a specific date identified that the resident did not have the specific fall interventions in place.

PSW and RPN both acknowledged the specified fall prevention interventions should have been in place at the time of the observation.

The staff failed to ensure the resident had the specified fall prevention interventions in place, which put the resident's safety at risk.

(ii) The resident's responsive behavior care plan had specific interventions staff were to follow.

Observations completed on a specific date, identified that staff did not follow the care plan interventions specific to responsive behaviors.

Staff acknowledged they were aware of the resident's behavioral interventions, however they failed to apply those interventions as specified in the resident's care plan.

Staff's failure to respond to the resident's responsive behaviors as specified in their plan, resulted in the resident having potentially unmet needs, therefore putting the resident at risk for diminished quality of life.

Sources: Observations completed on two specific dates, interviews with RPNs and other relevant staff, and the resident's care plan.

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WRITTEN NOTIFICATION: Infection prevention and control

program

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

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

Infection prevention and control program

s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:

2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The Licensee failed to ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for at least 26.25 hours per week, in a home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rational and Summary

On a specific date, the Infection Prevention and Control (IPAC) Lead Back-up stated they work less then 26.25 hours on-site. The IPAC Manager stated the IPAC Lead Back-up came to the home twice a week for two to three hours each visit for IPAC support.

The Director of Care acknowledged the IPAC Lead Back-up did not complete 26.25

hours per week on-site, for a 192-bed home.

Failure to ensure the home had a designated IPAC Lead on-site for the required hours per week put the management of the infection prevention and control program at risk.

Sources: Interviews with IPAC Lead and other relevant staff, and an email from the IPAC Manger.

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COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:

- Provide re-education to the PSW on the home's policy to promote zero tolerance of abuse and neglect and the Resident Bill of Rights; document the education provided, including the date, the staff who were educated and the staff member who provided the education.
- Provide re-education to two RPNs on the monitoring and reporting of health status changes of the resident, specifically related to their diagnosis of congestive heart failure, and complying with Physician/NP Orders; document

the education provided, including the date, the staff who were educated and the staff member who provided the education.

Grounds

(i) The Licensee has failed to protect residents from abuse by anyone.

Rationale and Summary

Subsection 2 (2) (a) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date there was an incident that occurred that resulted in a resident sustaining an injury and, pain to another resident.

The Personal Support Worker (PSW) acknowledged when they transported the resident to the table, they did not look to ensure that the resident's lower limbs were clear of obstructions, resulting in the resident sustaining an injury. While that same PSW was adjusting another resident's footrest, that resident's footrest landed on another resident causing them pain.

Home's investigation notes noted that when the resident cried out in pain due to sustaining an injury, the PSW did not attempt to ask the resident why they were in pain.

RPNs described the PSW approach to care as aggressive and stated the PSW did not look to make sure the residents' limbs were safe when adjusting the wheelchairs. The RPNs stated the incident could have been prevented had the PSW slowed down and checked for safety.

The PSW's failure to assess for safety and, use appropriate techniques when transporting and adjusting resident wheelchairs to fit around their table, caused a resident pain and injured another resident.

Sources: Homes investigation notes, Interview with RPN and other relevant staff, residents' clinical records.

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(ii) The Licensee has failed to ensure resident #003 was not neglected by the licensee or staff.

Rational and Summary

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The resident had a specific diagnosis. On a specified date the resident presented with an identified condition.

The Nurse Practitioner (NP) assessed the resident and ordered the resident to be weighed daily for 7 days.

On a specified date, the RPNs documented in a progress note that the resident.

experienced an identified symptom and provided treatment.

Both RPNs acknowledged the resident's weight was not taken on a specified date nor did they communicate to the physician or NP about the resident's symptoms.

On a specified date the RPN recorded the resident's weight. The resident's total weight gain was an identified amount from their baseline weight. There was no documentation noted indicating that the NP or Physician were notified of the weight change.

The NP and Physician stated they were not updated regarding the resident's symptoms on the specified dates and should have been. NP acknowledged if they

or the physician had been kept updated of the resident's symptoms earlier interventions, such as transfer to hospital, could have been implemented.

On a specified date the resident was transferred to hospital due to their specific diagnosis.

Staff failed to protect the resident from neglect by failing to report the resident's worsening condition to the physician or NP and did not take the resident's weight as ordered, which resulted in the delay of medical treatment.

Sources: Interviews with RPNs and other relevant staff, and resident clinical records.

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This order must be complied with by

July 26, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #001 issued under the FLTCA, 2021, for inspection #2023-1238-0007, issued on 2023-05-01.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.