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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Public Report

Report Issue Date: April 10, 2025

Inspection Number: 2025-1238-0002

Inspection Type:
Complaint
Critical Incident

Licensee: North York General Hospital

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 1-4, 7-10, 2025

The following Critical Incident (CI) intakes were inspected:

- Intake #00141710/ CI #2744-000015-25 was related to a disease outbreak.
- Intake #00137650/ CI #2744-000006-25 was related to unexpected death of resident.
- Intake #00140157/ CI #2744-000011-25 was related to fall prevention and management.

The following Complaint intakes were inspected:

- Intake #00136980 was related to improper medication administration and concerns with resident care.

The following intakes were completed in this CI inspection:

- Intakes #00136935/ CI #2744-000003-25 and #00138925/ CI #2744-000007-25 were related to fall prevention and management.
- Intakes #00139693/ CI #2744-000009-25, #00140245/ CI #2744-000010-25. #00141146/ CI #2744-000013-25 and #00136137/ CI #2744-000001-25 were related to disease outbreaks.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate in the implementation of the resident's plan of care. The SDM was not informed of the physician's overall physical assessment of the resident on a certain date.

Sources: Complaints binder; resident's clinical records; and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that a Personal Support Worker (PSW) was kept aware of the contents of a resident's plan of care. The PSW confirmed that they were not aware of the contents of resident's plan of care, related to nutrition and specific staff providing care.

Sources: Resident's plan of care; progress notes; and interview with the PSW.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that all doors leading to stairways or doors that residents do not have access to were kept closed and locked.

During an observation in the fourth-floor home area, a door leading to stairway #2 was found unlocked. Environmental Service Manager (ESM) stated that during

preparation for annual fire safety maintenance, the Magsafe alarm system was turned off for approximately two hours, during which time all doors in the home leading to the stairway were not locked.

Sources: Observations and Interview with the ESM.

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee has failed to ensure that residents who ate independently were monitored during breakfast on a home area. Activation Aide and Registered Practical Nurse (RPN) both stated that no staff were monitoring the residents who ate their breakfast independently inside their rooms on a specific home area during an outbreak on a certain date. The home's policy titled, "Dining- Tray Service" indicates that the PSW would be required to conduct supervision/ assistance for residents on tray service. DOC stated that there should have been PSWs monitoring residents when they ate inside their rooms without staff assistance.

Sources: Home's policy titled, "Dining-Tray Service, dated September 2016; Home's investigation notes; Interview with staff.