Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 26, 2019	2019_641665_0006	009304-18, 016693-18, 017568-18, 025788-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Norfinch Care Community
22 Norfinch Drive NORTH YORK ON M3N 1X1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 19, 20 and 21, 2018. Off site March 22, 2019.

The following intake logs were inspected:
- Log #016693-18
- Log #009304-18/CIS #2918-000005-18
- Log # 017568-18/CIS #2918-000008-18
All related to resident to resident abuse.

- Log #025788-18/CIS #2918-000012-18 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Relations Coordinator (RRC), Registered Nurses (RN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector reviewed clinical health records, observed staff and resident interactions, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

The home submitted a critical incident system (CIS) report on an identified date related to an allegation of staff to resident verbal abuse. The CIS report indicated that resident #003 informed their family member that a PSW spoke to them inappropriately and called them an inappropriate name. The home conducted an investigation and re-assigned PSW #105 to another resident home area (RHA).

A review of two progress notes in point click care (PCC) dated the same day as the CIS report, made by the ED and DOC indicated that a family member reported an allegation of verbal abuse towards resident #003 by a PSW.

A review of the home's investigation notes indicated that PSW #105 provided care to the resident during an identified shift and date. The investigation further indicated that PSW #105 denied the allegation made by the resident. As a result of the investigation, the home found that PSW #105 violated the organization's policies which included the Resident's Bill of Rights.

In an interview, resident #003 indicated that PSW #105 called them an inappropriate name and spoke to them inappropriately. The resident stated that they felt sad after the incident and was not treated with respect when PSW #105 provided care to them.

In an interview, PSW #105 denied the allegations made by resident #003 and was moved to another RHA.

In an interview, the ED indicated that the home conducted an investigation and PSW #105 was moved to another RHA and violated the Resident's Bill of Rights. The ED acknowledged that resident #003 was not treated with respect by PSW #105.

2. The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the ActionLine on an identified date, related to an allegation of verbally abusive behaviour towards resident #001 by resident #002.

In an interview, the complainant indicated that resident #002 was verbally abusive to

resident #001 since resident #001's admission to the home. The complainant stated that resident #001 was scared for their safety.

A review of resident #001's clinical records indicated that they were admitted to the home on an identified date. Resident #001's progress notes in PCC had documentation over an identified four month period regarding verbally inappropriate comments made by resident #002 towards resident #001.

In interviews, RN #102 and PSW #103 indicated that residents #001 and #002 were cognitively aware and shared the same room. The RN and PSW indicated that resident #002 was verbally inappropriate towards resident #001. The RN indicated that resident #002 would swear and call resident #001 an identified animal and resident #001 had expressed to the staff that they were scared of resident #002. The PSW stated that resident #002 would scream and swear at resident #001. Both RN #102 and PSW #103 acknowledged that resident #001 was not treated with respect while living in the home.

In an interview, resident #001 indicated that they were taunted and teased by resident #002, who was their roommate. Resident #001 stated that they felt scared that resident #002 would hurt them while they were in bed.

At the time of the inspection, resident #002 was not a resident of the home.

In interviews, the DOC and the RRC indicated that residents #001 and #002 shared the same room. Both stated that resident #002 was verbally inappropriate towards resident #001 during an identified four month period. The RRC indicated that resident #002 was discharged from the home on an identified date at the end of the four month period. The DOC and RRC indicated that they had numerous conversations with resident #002 regarding their behaviour towards resident #001 and had brought community police officers to speak to resident #002 as well, but resident #002 continued to be verbally inappropriate towards resident #001. Both the DOC and RRC indicated that resident #001 had expressed they were scared of resident #002. The DOC acknowledged that resident #001 was not treated with respect and dignity while living in the home.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CIS report on an identified date, related to an allegation of staff to resident verbal abuse towards resident #003.

A review of the resident #003's written plan of care, indicated that the resident required two team members to provide care for three identified personal care tasks.

A review of the home's investigation notes indicated that PSW #105 was assigned to the resident on an identified shift and date and provided care to the resident. PSW #105 indicated that they provided care to the resident with the assistance of PSW #108 and RN #109. When the home followed up with PSW #108 and RN #109, they indicated that they did not assist PSW #105 with resident #003.

In an interview, PSW #105 indicated that the resident required two people to complete two specified tasks. The PSW stated that they had completed the two specified tasks at the beginning and prior to the end of their shift on the identified date, with the assistance of PSW #108 and RN #109.

In an interview, the ED indicated that resident #003's plan of care stated that two staff members are required to provide care. The ED stated that the home reviewed the home's surveillance camera and determined that PSW #105 provided care to the resident on their own. The ED acknowledged that care was not provided as specified in the plan of care for resident #003.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 11th day of April, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.