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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# Public Report

**Report Issue Date:** December 18, 2024

**Inspection Number:** 2024-1402-0006

**Inspection Type:**
Critical Incident
Follow up

**Licensee:** 2063414 Ontario Limited as General Partner of 2063414 Investment LP

**Long Term Care Home and City:** Norfinch Community, North York

## INSPECTION SUMMARY

The inspection occurred on the following date(s): December 5-6, 9-11,13, 2024
The following intake(s) were inspected:

- Intake: #00123364 - [Critical Incident (CI): 2918-000020-24] – related to staff to resident abuse
- Intake: #00125958 – [CI: 2918-000024-24] – related to staff to resident abuse
- Intake #: 00127683 [CI: 2918-000026-24] - related to infection prevention and control
- Intake #: 00128504 – Follow-up to Compliance Order #001 from inspection #2024-1402-0004 – duty to protect

The following intake(s) were completed:

Intake: #00124732 – [CI: 2918-000022-24] - related to infection prevention and control

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1402-0004 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

# 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: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The home has failed to ensure that there was posted signage at entrances and

throughout the home in accordance with the "IPAC Standard for Long Term Care Homes September 2023" (IPAC Standard). Specifically, no signs were posted that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual as required by Additional Screening requirements 11.6 under the IPAC Standard. quest the other options

**Rationale and Summary**
During the inspection it was observed the signs and symptoms of infectious diseases for self-monitoring signage was not posted at the entrance nor throughout the home on December 5-6, 2024.

On December 11, 2024, it was observed that signage was posted on the main entrance, before entering into the elevators, and near the main reception desk beside the staff time clock.

Failure to post signage of screening measures in the home may increase the risk of infection transmission.

**Sources**: Observations; and interview with IPAC Lead
[000711]

Date Remedy Implemented: December 11, 2024

## WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (1) (c)**
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care provided clear directions to staff and others who provided care.

**Rationale and Summary**
A resident's substitute decision-maker voiced concern that a service provider was in the resident's room without any other staff member in attendance. A Registered Nurse (RN) indicated the home was going to update the written plan of care to address this but acknowledged it had not been completed.

Failing to include clear directions to staff put the resident at risk for distress.

**Sources:** Resident's written plan of care and progress notes, and an interview with a RN. [501]

## 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)**
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 has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

**Rationale and summary**
A resident's care plan indicated that staff were to provide them with two-person assistance with their Activities of Daily Living (ADL).

Record review and interview with a Personal Support Worker (PSW) indicated that they assisted the resident with an ADL without assistance from another staff.

Failing to follow the plan of care put the resident at risk for potential harm.

**Sources**: Resident's care plan; home's investigation notes and interview with a PSW. [000711]

## WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee has failed to ensure a resident was protected from neglect by a PSW.

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."

**Rationale and Summary**
At the beginning of a shift that began on specified date, a PSW and a resident had a verbal altercation. The PSW then asked another staff for assistance and care was completed. The PSW stated they did not feel safe to provide care for the resident for the rest of the shift and did not inform the registered staff of this. As a result, the resident went without care for approximately seven hours and was found soaked

and soiled the following morning. As well, a Registered Practical Nurse (RPN) found that the resident's blood sugar that morning was high and feeling stressed.

Failing to provide care resulted in the resident being left soiled and upset which jeopardized their health and well-being.

**Sources:** The home's investigation notes, resident's progress notes and interviews a PSW and other staff. [501]

## WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that staff who had reasonable grounds to suspect that a resident was abused immediately reported their suspicion and the information upon which it was based to the Director.

**Rationale and Summary**
A resident told a RPN that a PSW had been rude to them. The RPN told a Charge Nurse who interviewed the resident the same day. The resident stated the staff were rough with them. The Charge Nurse informed a manager-on-call, and it was decided to find out more information. It was reported to an evening RN to ask the night RN to interview the resident. The night RN and RPN interviewed the resident

who told them they had been abused. The night RN then wrote a note to the Director of Care (DOC) which was not received until two days after. The Executive Director and DOC then reported the allegations to the Director.

Failing to immediately inform the Director of a suspicion of abuse put the resident at risk for further harm.

**Sources:** The home's investigation notes and interviews with the DOC and other staff. [501]

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The home has failed to ensure that Additional Precautions were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, additional personal protective equipment (PPE) requirements including appropriate selection application as required by Additional Requirement 9.1 (f) under the IPAC standard.

**Rationale and Summary**
A resident was on droplet and contact precautions. The precautions signage on the

resident's door indicated that eye protection was required when within two metres of the resident.

A Housekeeping staff was within two metres of the resident without the required eye protection. The staff stated that they did not wear the required eye protection as they forgot.

There was a risk of infection transmission to the Housekeeping staff, other residents and staff when the required eye protection was not worn by the Housekeeping staff.

**Sources**: Observation; interviews with the Housekeeping staff and the IPAC Lead. [000711]

## WRITTEN NOTIFICATION: Police Notification

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 105**
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the police were immediately notified of an alleged incident of abuse and neglect.

**Rationale and Summary**
A resident reported being verbally abused to an RPN and RN. However, the police were not notified until two days later. The DOC confirmed the staff did not immediately inform the police.

Failing to inform the police of an allegation of abuse put the resident at risk for further harm.

**Sources:** The home's investigation notes, resident's progress notes and an interview with the DOC. [501]

## WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in an area or medication cart that was secure and locked.

**Rationale and Summary**
A medication room door was observed to be propped wide open. Inside the medication room was an unlocked medication cart that contained drugs. A RN returned to the area and acknowledged the door and medication cart should have been locked. The DOC stated that this situation posed a risk to residents as they had access to drugs that might cause them harm if ingested.

**Sources:** An observation and interviews with the RN and the DOC. [501]

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