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 Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 10, 2022	
Inspection Number: 2022-1238-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: North York General Hospital	
Long Term Care Home and City: Seniors' Health Centre, North York	
Lead Inspector Nital Sheth (500)	**Inspector Digital Signature** Nital Sheth Digitally signed by Nital Sheth Date: 2022.11.15 09:33:42 -05'00'
Additional Inspector(s) Joy Ieraci (665)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 27-28, 31, November 1-4, 7-8, 2022.

The Seniors Health Centre Proactive Inspection intake was inspected in this inspection.

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

Quality Improvement
Food, Nutrition and Hydration
Residents' Rights and Choices
Prevention of Abuse and Neglect
Infection Prevention and Control
Residents' and Family Councils
Resident Care and Support Services
Safe and Secure Home
Medication Management

Skin and Wound Prevention and Management
Pain Management
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)
FLTCA, 2021 s. 6 (10) b

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised at any other time when, their care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary:
The resident's plan of care indicated that a device was required to manage the resident's responsive behaviour.

The device was not observed in the resident's room.

Resident Assistant (RA) #123 confirmed that the device had not been in place for a period of time.

Assistant Director of Care (ADOC) #101 indicated that they had followed up with the registered staff and the device was no longer needed.

The resident's plan of care was revised on November 3, 2022.

Sources: Observation, review of the resident 's care plans, and interviews with RA #123 and ADOC #101.

Date Remedy Implemented: November 3, 2022 [665]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 s. 12 (1) 3

The licensee has failed to ensure doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

Rationale and Summary:
In four different observations, the oxygen cylinder storage room on the first-floor resident home area (RHA) was not equipped with a lock and was unlocked. There were no residents in the vicinity at the time of the observations.

Registered Practical Nurse (RPN) #104 indicated that the door had been without a lock and was unlocked for over a month. They confirmed the storage room was a nonresidential area.

On November 8, 2022, the storage room door was locked and equipped with a lock.

Sources: Observations on three identified days, and interviews with RPN #104 and other staff.

Date Remedy Implemented: November 8, 2022

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 s. 12 (1) 3

The licensee has failed to ensure that all doors leading to non-residential areas were kept

closed and locked when they were not being supervised by staff.

Rationale and Summary:
During the initial tour of the home, the following doors leading to non-residential areas were open and unlocked:

1. Fourth floor RHA's laundry room was unlocked;
2. Fourth floor RHA's oxygen cylinder storage room was open and unlocked;
3. Fourth floor RHA's storage room which had equipment and supplies was unlocked and;
4. First floor RHA's spa room was unlocked.

There were no residents in the vicinity at the time of the observations.

RPNs #106 and #108 and RA #128 indicated that the rooms were non-residential areas and were to be kept closed and locked.

RA #128 locked the storage room and RPN #108 locked the spa room immediately during the observations. The laundry room was observed locked on November 1, 2022, and the oxygen cylinder room door was closed and locked on November 8, 2022.

Sources: Observations on three identified days and interviews with RPNs #106 and #108 and RA #128.

Date Remedy Implemented: November 8, 2022 [665]

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22 s. 20 (b)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

Rationale and Summary:

During the initial tour of the home, the call bell at a resident's bedside in room was not on at all times. The call bell did not activate when pressed. In another observation RA #109 confirmed that the bedside call bell was not working.

Facility Technician #102 fixed the call bell the same day.

Sources: Observations, and interviews with RA #109, Facility Technician #102 and other staff.

Date Remedy Implemented: October 27, 2022 [665]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, related to their specified care.

Rationale and Summary
The resident's care plan and kardex directed staff to assist the resident for specified care after meals.

Interviews with RA, they indicated they had not assisted the resident to receive the specified care on two occasions after meals. The RA stated they were not aware that the care plan related to the specified care.

The resident was reliant on staff to assist them for the specified care. There was a risk to the resident's health when they did not follow the plan of care regarding assistance required by the resident for the specified care.

Sources: Review of the resident's care plan and kardex and interviews with RA and other staff. [665]

WRITTEN NOTIFICATION: Windows

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents cannot be opened more than 15 centimeters (cm).

Rationale and Summary
During the initial tour of the home, Facility Technician #102 measured three resident room windows that opened to the outdoors. The window openings were more than 15 cm as follows:

Facility Technicians #102 and #126 indicated that all the window openings in the home were between 22 to 24 cm. Facility Technician #126 indicated that all of the home's windows were inspected and a contractor will be in the home later in the week to replace some windows and install window blocks to ensure that the window openings were no more than 15 cm.

The scope of work indicated that 23 windows were to be replaced and 151 window blocks were to be installed in the home.

There was a risk of harm and injury to residents if they attempted to exit the window through an opening that was greater than 15 cm.

Sources: Observations on two identified days; review of window opening measurements and scope of work and interviews with Facility Technicians #102 and #126 and other staff. [665]