Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 9, 2020	2020_751649_0019	019103-20	Critical Incident System

Licensee/Titulaire de permis

Norwood Nursing Home Limited
122 Tyndall Avenue TORONTO ON M6K 2E2

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

Norwood Nursing Home
122 Tyndall Avenue TORONTO ON M6K 2E2

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 27, 2020.

The following intake was completed in this Critical Incident System (CIS) Inspection:
Log #019103-20/ CIS #2201-000009-20 related to an outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and resident.

During the course of the inspection the inspector reviewed residents' health records, staffing schedules, and conducted observations related to the home's care processes.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident being cohorted was equipped with a resident-staff communication and response system at their bedside.

During a tour of the home the inspector observed a resident did not have access to a call bell for use at their bedside. The resident was moved to a different location for cohorting purpose and told the inspector that they did not have access to a call bell. Absence of an accessible call bell at the resident's bedside placed them at risk.

The Assistant Administrator acknowledged that the home failed to ensure that the resident had access to a call bell at their bedside, after they were moved for cohorting.

Sources: Observation of the resident and interviews with the resident and Assistant Administrator. [s. 17. (1) (d)]

Issued on this 14th day of October, 2020

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

Original report signed by the inspector.