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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Original Public Report

Report Issue Date: January 24, 2024
Inspection Number: 2023-1057-0005
Inspection Type: Complaint Critical Incident
Licensee: Norwood Nursing Home Limited
Long Term Care Home and City: Norwood Nursing Home, Toronto

Lead Inspector	**Inspector Digital Signature**
Oraldeen Brown (698)	Oraldeen C Brown 2024.02.07 15:33:59 -05'00'

Additional Inspector(s) Noreen Frederick (704758)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 13, 14, 18, 19, 20, 21, 22, 2023.

The following intake(s) were inspected:

- Intake #00098930, Critical Incident System (CIS) report #2201-000008-23 related to falls prevention and management.
- Intake #00098961, CIS #2201-000008-23 and #00098996, CIS #2201-000007-23 related to prevention of abuse and neglect.
- Intake: #00100896, #2201-000009-23 related to an outbreak.

The following complaint intake was inspected:

Intake #00101582 related to neglect of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
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)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
Required information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
The inspector observed that the home's policy to promote zero tolerance of abuse and neglect of resident was not posted in the home on December 13, 2023.

The Executive Director/Director of Care (ED/DOC) acknowledged that the above-mentioned policy should have been posted on the bulletin board in the reception area of the home. They checked the area and indicated that they would immediately post it.

Sources: Observations and interview with the ED/DOC.

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Date Remedy Implemented: December 13, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1)
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 104 (3) of the Act.
3. The most recent audited reconciliation report provided for in clause 288 (1) (a) of this Regulation.
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 85 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 28 of the Act.
6. Any notice of public consultation that the Director provides to the licensee and

identifies to be for posting in the home.
7. The physical address of the long-term care home.
8. The approximate number of licensed beds at the home.
9. Direct contact information, including a telephone number and email address that are monitored regularly for,
i. the Administrator, and
ii. the Director of Nursing and Personal Care.
10. The current version of the visitor policy made under section 267.
11. Any notice of administrative penalty issued against the licensee under section 158 of the Act.

The licensee has failed to ensure that the information required to be posted in the home under section 85 of the Act includes the current version of the visitor policy.

Summary and Rationale
During a tour of the home, the visitor's policy was not posted in the home.

The ED/DOC acknowledged that the visitor's policy was not posted in the home and should have been posted on the bulletin board in the reception area. They checked the area and indicated that they will immediately post it.

There was no negative risk to residents' health, wellbeing, or safety.

Sources: Observations and interview with ED/DOC.

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Date Remedy Implemented: December 13, 2023

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 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 that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Summary and Rationale

A Personal Support Worker (PSW) provided afternoon snacks to approximately eight residents on the first floor. They provided snacks to residents in their rooms and in common areas on the unit.

The PSW did not perform hand hygiene before and after encountering the residents' environment, and in between providing snacks to residents.
Approximately eight residents were not assisted with hand hygiene prior to being served their snacks.

The PSW acknowledged that they did not perform hand hygiene before and after encountering residents' environment and in between the provision of snacks to residents. The ED/DOC noted that staff should have performed hand hygiene in between serving residents their snacks and should have assisted residents with hand hygiene prior to the snack pass.

Staff's failure to follow proper hand hygiene practices before providing snacks to residents increased the risk of spreading infections in the home.

Sources: Observations on December 20, 2023, from 1403 to 1415 hours; interviews with ED/DOC and PSW.

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 a hip protector and a functional bed alarm set out in resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
(i) The resident's care plan indicated that they were at high risk of fall, and required a specific device at all times.

It was noted that the resident was not using the device.

A Registered Practical Nurse (RPN) stated that the device was not provided to the resident as per their plan of care. The ED/DOC acknowledged that the resident was at high risk of falls, and the device should have been provided to the resident at all times as indicated in the care plan.

Failure to provide the device to the resident as set out in their care plan may put them at risk of injury following a fall.

Sources: Inspector's observations, resident's care plan, and interviews an RPN, and ED/DOC.

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Rationale and Summary:
(ii) A Resident had an unwitnessed fall that resulted in several injuries.

The resident had two devices as part of their plan of care. At the time of the fall, the resident was not using the first device. Additionally, as indicated in the resident's plan of care, the second device to aid in their fall prevention was non-functional. The resident's care plan indicated "staff to ensure that the resident was using the first device at all times." It also indicated "staff to ensure that the second device was working at all times."

A PSW stated that they were aware that the resident was not using the first device but they did not provide it. They also stated that they did not check the second device to ensure that it was functional. The ED/DOC acknowledged that the resident was at high risk of fall and that both devices should have been in place and functional at all times as indicated in the care plan.

Failure to provide the first device and a functional second device to the resident as set out in their care plan puts them at risk of injury following a fall.

Sources: Resident's clinical records, and interviews with a PSW, and ED/DOC.
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WRITTEN NOTIFICATION: Duty to protect

NC #005 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 protect resident #003 from physical abuse by resident #002.

Rationale and Summary

According to O. Reg. 246/22, s. 2 (1), "physical abuse" means, subject to subsection (2), "The use of physical force by a resident that causes physical injury to another resident".

Resident #003 was hit by resident #002 when resident #003 tried to use a shared space. This led to an injury to resident #003. To prevent the reoccurrence, a Registered Nurse (RN) prohibited resident #003 access to the shared space.

A second incident occurred later that same day, when resident #003 attempted to use the shared space when access was no longer prohibited. Resident #002 hit resident #003 with an object causing several injuries. As a result of their injuries, both residents were transferred to hospital. Resident #002 was relocated to another room after the second incident.

A PSW and a registered staff stated they did not check the shared space to ensure access remain prohibited. The Behavioral Support of Ontario (BSO) Lead and Assistant Director of Care (ADOC) stated that both incidents could have been prevented if resident #002 was relocated to an available empty room after the first

incident, and if the staff had checked to ensure that the shared space prohibited access at all times.

Failure to implement and comply with interventions to prevent physical abuse resulted in harm to resident #003.

Sources: Resident's clinical records, and interview with PSW, RPN, BSO Lead, and ADOC.

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WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

Summary and Rationale
A PSW was observed at the first-floor nursing station without a mask. Signages inside the home indicated that mask was to be always worn.

The PSW acknowledged they were not wearing the required Personal Protective Equipment (PPE) while inside the home. ED/DOC acknowledged that mask was to be worn by everyone while inside the home.

Staff's failure to always wear a mask while inside the home put residents at risk for infection.

Sources: Observations on December 14, 2023; review of IPAC Standards; interviews with a PSW and ED/DOC.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident had an unwitnessed fall that resulted in several injuries.

An RN stated that the resident was in excruciating pain and having difficulty breathing. One PSW stated that they manually transferred the resident with another PSW from the floor. The ED/DOC acknowledged that unsafe transferring and positioning techniques were used when the resident fell.

As a result of improper transferring techniques, the resident was placed at risk for further injuries.

Sources: Resident's clinical records, Long-Term Care Home's (LTCH's) policy NUM-IV-73 "Falls Policy" last reviewed September 13, 2023, and interviews with PSW, RN and ED/DOC .

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WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall that resulted in several injuries.

An RN stated that they did not complete a post-fall assessment. The ED/DOC acknowledged that registered staff were expected to complete a post-fall assessment when the resident fell.

Failing to complete a post-fall assessment put the resident at risk for delayed identification of changes to their health status following a fall.

Sources: Resident's clinical records, LTCH's policy NUM- IV-73 "Falls Policy" Last reviewed September 13, 2023, and interviews with an RN, and ED/DOC.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to ensure that staff complied with the home's responsive behaviour and behaviour management policy.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that resident monitoring and internal reporting protocols to meet the needs of residents with responsive behaviours and were complied with.

Specifically, staff did not complete the Dementia Observational System (DOS) data collection sheet, which was included in the licensee's responsive behaviours and behaviour management policy.

Rationale and Summary
Resident #003 was hit by resident #002, when resident #003 tried to use a shared space. To prevent the reoccurrence, RN #101 implemented the DOS monitoring every thirty minutes.

A second incident occurred later that same day, when resident #003 attempted to use the shared space when access was no longer prohibited. Resident #002 hit resident #003 with an object causing several injuries. As a result of their injuries, both residents were transferred to hospital.

The home's responsive behaviour and behaviour management policy indicated that a team approach was to be used in the management of responsive behaviours and the PSWs were required to complete monitoring.

The PSW that was assigned to the resident stated that they did not monitor resident #002 every 30 minutes but had signed the DOS monitoring sheet indicating that they did. The BSO Lead and ADOC both stated that the PSW was required to monitor the resident every 30 minutes and they should not sign the DOS data collection sheet if they did not monitor the resident.

Failure to monitor resident #002 resulted in harm to resident #003.

Sources: Resident's DOS data collection sheet, LTCH's policy NUM–VII-33 titled, 'Responsive Behaviour & Behaviour Management', Last reviewed January 5, 2023, resident's clinical records, and interviews with PSW, BSO Lead and ADOC.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each

of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically COVID-19 outbreak.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to a COVID-19 outbreak.

The ADOC acknowledged that they did not immediately submit the CIS report of COVID-19 outbreak to the Director.

Failure to submit CIS report within the appropriate timeframe may have resulted in the Director being unaware of the outbreak and taking necessary actions.

Sources: CIS report #2201-000009-23, and interview with ADOC.

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