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

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Original Public Report

Report Issue Date: September 6, 2024
Inspection Number: 2024-1057-0002
Inspection Type: Critical Incident
Licensee: Norwood Nursing Home Limited
Long Term Care Home and City: Norwood Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 12, 2024

The following intake(s) were inspected:

- Intake: #00111883/Critical Incident (CI) #2201-000003-24 - related to a disease outbreak
- Intake: #00117264/CI #2201-000004-24 - related to falls prevention and management

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

Infection Prevention and Control
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 #001remedied pursuant to FLTCA. 2021. s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the butterfly fall risk logo was present for a resident.

In accordance with 0. Reg 246/22, s. 11(1) (b), the licensee is required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, staff did not comply with the home's Falls Prevention Policy (NUM-IV-73, date reviewed April 3, 2024) to place a butterfly fall risk logo for the resident who were identified to be at risk for falls.

Rationale and Summary
A resident was identified to be at risk for falls.

The home's Falls Prevention Policy directs staff to use a butterfly fall risk logo for residents who were at risk of falling.

On an occasion, the inspector did not observe the presence of a butterfly fall risk logo for a resident. A Registered Practical Nurse (RPN) acknowledged the resident did not have a butterfly fall risk logo indicating their fall risk.

During another observation, the inspector noted the butterfly risk logo was present the resident.

Failure to ensure the fall risk logo was present may lead to staff not being aware of this risk.

Sources: Observations, a resident's clinical records, the home's Falls Prevention policy (NUM-IV-73, date reviewed April 3, 2024) and interviews with staff.

Date Remedy Implemented: August 9, 2024

WRITTEN NOTICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA 2021. s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
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,
(a) the planned care for the resident.

The licensee has failed to ensure that the planned care for a resident was written in their plan of care.

Rationale and Summary
A resident had responsive behaviour and required assistance from staff with the application of a specific device.

A Personal Support Worker (PSW) and an RPN verified that staff were responsible to ensure the resident wore the device due to their responsive behaviour. However, the application of the device was not stated in the resident's care plan.

Failure to have the intervention stated in the resident's plan of care poses the risk of staff not monitoring its application.

Sources: Observation, a resident's clinical records and interviews with staff.

WRITTEN NOTICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA 2021. s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when an intervention was not effective.

Rationale and Summary
A resident's care plan indicated that the resident required an equipment for their falls prevention and management.

A PSW and an RPN both stated that staff had been unsuccessful in applying the equipment for the resident as they would refuse it. Both the PSW and RPN acknowledged that the use of the intervention for the resident and the care plan should have been updated to reflect this.

The ADOC acknowledged that the resident's plan of care was not revised when the equipment was not used for their fall prevention and management.

Failure to ensure that the resident's plan of care was reassessed and revised poses the risk of lack of staff awareness to not apply the equipment.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA. 2021. s. 154 (1) 1.

Non-compliance with: 0. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that Head Injury Routine (HIR) monitoring was completed for a resident prior to the resident's transfer to and return from the hospital.

In accordance with 0. Reg 246/22, s. 11(1) (b), the licensee is required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Head Injury Routine Policy (NUM-IV-64) to complete HIR monitoring prior to the resident's transfer to the hospital and returning from the hospital within 24 hours.

Rationale and Summary
A resident sustained a fall with injuries. They were taken to the hospital for further assessment and returned to the home within 24 hours.

The home's Head Injury Routine (HIR) Policy directs registered nursing staff to initiate and complete HIR monitoring for unwitnessed fall for a minimum of 48 hours post incident, and to continue HIR monitoring for a period of 24 hours when a resident returns from the hospital within 24 hours.

The resident's clinical records indicated that HIR monitoring was not completed prior to their transfer to the hospital. In addition, HIR monitoring was not continued upon the resident's return from the hospital with 24 hours.

An RPN admitted that they did not complete HIR monitoring after the resident's fall prior to their hospital transfer. The ADOC acknowledged registered nursing staff did not follow the home's policy in completing HIR monitoring for the resident at the required frequency prior to the resident's transfer to and return from the hospital.

Failure to complete HIR monitoring put the resident at risk of staff not detecting possible injury.

Sources: A resident's clinical records, the home's HIR Policy (NUM-IV-64), interviews with staff.