



**Ministry of Health and
Long-Term Care**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Bureau régional de services de
Hamilton
119 rue King Ouest 11ième étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|--------------------------------|--|
| Jun 25, 2015 | 2015_188168_0018 | H-006916-15 | Critical Incident System |

Licensee/Titulaire de permis

THE CORPORATION OF NORFOLK COUNTY
50 Colborne Street South SIMCOE ON N3Y 3H3

Long-Term Care Home/Foyer de soins de longue durée
NORVIEW LODGE
44 ROB BLAKE WAY P. O. BOX 604 SIMCOE ON N3Y 4L8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
LISA VINK (168)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): June 24, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Clinical Care Coordinator, registered nursing staff, personal support workers and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**



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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

Legendé

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).

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:**

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on interdisciplinary assessments of the resident that included any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

Resident #10 demonstrated responsive behaviours shortly after admission to the home in 2015. The progress notes identified that the resident exhibited behaviours which included, but were not limited to: attempting to take other residents out of their bed/chair, becoming possessive of another resident and invading other resident's personal space, with the potential to cause harm. A review of current and past plans of care included problem statements related to behaviours and mood needs; however, did not include the specific behaviours identified above nor triggers and the interventions in place to manage, as confirmed during an interview with registered staff. [s. 26. (3) 5.]

Additional Required Actions:

**VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2)
the licensee is hereby requested to prepare a written plan of correction for
achieving compliance to ensure that the responsive behaviour plan of care is
based on interdisciplinary assessments of the resident that includes any mood
and behaviour patterns, any identified responsive behaviours and any potential
behavioural triggers and variations in resident functioning at different times of the
day, to be implemented voluntarily.**



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Issued on this 25th day of June, 2015

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

Original report signed by the inspector.