Ontario

Ministry of Health and Long-Term Care

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2016	2016_511586_0007	026888-16	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

JESSICA PALADINO (586)

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 1, 2016

The following Critical Incident System (CIS) Inspection was completed: 026888-16.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinator (RCC), Registered Dietitian (RD), Nutritional Services Supervisor (NSS), Behavioural Support Ontario (BSO) team, registered and non-registered staff, and residents.

During the course of the inspection, the inspector reviewed resident health records, reviewed the home's internal investigation notes, observed the home area, and spoke with residents and staff.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **2 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	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). 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 LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

On an identified date in 2016, resident #001 deceased due to aspiration of food.

Resident #001's documented plan of care, which front line staff use to direct care, indicated that the resident was on a regular diet, and it included specific interventions for staff to follow regarding the resident's diet.

During interview with resident #002 on September 1, 2016, they revealed that resident #001 had identified behaviours related to food consumption. Interview with PSW #304 also indicated that the resident had the identified behaviours.

Review of the resident's health record revealed an initial assessment by the BSO team completed upon the resident's admission, in which the two BSO staff documented that the resident was at risk for choking due to the manner in which they ate. Interview with the BSO team confirmed that they obtained this information from the Community Care Access Centre (CCAC) admission report.

When asked how their assessments were relayed to staff, the BSO team indicated that they would document their assessments in the resident's paper chart and/or pass the information along verbally to staff. The BSO team informed the LTC Inspector of their concern of staff not reading all of their assessment notes when put into resident charts.

In an interview with the DOC and Resident Care Co-ordinator (RCC), they confirmed that if the BSO staff verbally communicated any information to the staff, they would document the name of the staff member and what was communicated in their notes. Review of the BSO assessment notes for the resident did not identify any documentation to demonstrate that the resident's chewing difficulties and history of aspiration was communicated verbally to front line staff.

Interview with PSW #304 confirmed that they were not aware of the resident's history of choking prior to admission or specific eating habits.

The DOC and RCC confirmed that the information regarding the resident's history of choking and eating habits was not communicated to staff; therefore, the staff did not collaborate in the assessment of the resident's eating risks. [s. 6. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's nutrition and hydration program included the implementation of interventions to mitigate and manage resident #001's risks related to nutrition care and dietary services and hydration.

On an identified date in 2016, resident #001 deceased due to aspiration of food.

Interview with resident #002 on September 1, 2016, confirmed that resident #001 the resident had identified behaviours related to food consumption. PSW #304 confirmed the behaviours as well.

Review of the resident's health file identified the CCAC admission report in which information was identified regarding the resident's specific eating habits and history of choking. This included the need for the resident to be supervised closely.

Resident #001's documented plan of care, which front line staff use to direct care, indicated that the resident was on a regular diet, and it included specific interventions for staff to follow regarding the resident's diet.

Review of the RD's initial assessment completed in 2016, documented a specific intervention for the resident; however, interview with the RD and NSS confirmed that the resident's plan of care did not include the other necessary interventions recommended in the CCAC report to mitigate the resident's risk of choking. The RD confirmed that this information should have been conveyed onto the resident's plan of care and initiated by staff.

This information was confirmed with the DOC and RCC. The home did not implement interventions to mitigate and manage resident #001's choking risk. [s. 68. (2) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to inform the Director immediately, in as much detail as is possible in the circumstances, or an unexpected or sudden death, including a death resulting from an accident.

On an identified date in 2016, resident #001 deceased due to aspiration of food.

Interview with the DOC on September 2, 2016, confirmed that the Director was not notified of the sudden death until the following day, on August 30, 2016, at 1030 hours, and confirmed the Director should have been informed of the incident immediately. [s. 107. (1)]

Issued on this 21st day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2016_511586_0007
Log No. / Registre no:	026888-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF NORFOLK COUNTY 50 Colborne Street South, SIMCOE, ON, N3Y-3H3
LTC Home / Foyer de SLD :	NORVIEW LODGE 44 ROB BLAKE WAY, P. O. BOX 604, SIMCOE, ON, N3Y-4L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Nolan

To THE CORPORATION OF NORFOLK COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that staff and others involved in the different aspects of care for residents in the home collaborate with each other in the assessment of the residents so that their assessments are integrated and consistent with and complement each other. This shall include the development and implementation of a process to ensure that all pertinent information obtained upon admission and through any other assessment are effectively communicated to all staff, including Community Care Access Centre notes, Behavioural Support Ontario assessments, and Registered Dietitian assessments.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #001 experienced, the scope of one isolated incident, and the Licensee's history of non-compliance (VPC) on the July 19, 2016 Resident Quality Inspection with the s. 6. (4) (a) related to the resident's plan of care.

The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

On an identified date in 2016, resident #001 deceased due to aspiration of food.

Resident #001's documented plan of care, which front line staff use to direct care, indicated that the resident was on a regular diet, and it included specific interventions for staff to follow regarding the resident's diet.

During interview with resident #002 on September 1, 2016, they revealed that resident #001 had identified behaviours related to food consumption. Interview with PSW #304 also indicated that the resident exhibited these behaviours.

Review of the resident's health record revealed an initial assessment by the BSO team completed upon the resident's admission, in which the two BSO staff documented that the resident was at risk for choking due to the manner in which they ate. Interview with the BSO team confirmed that they obtained this information from the Community Care Access Centre (CCAC) admission report.

When asked how their assessments were relayed to staff, the BSO team indicated that they would document their assessments in the resident's paper chart and/or pass the information along verbally to staff. The BSO team informed the LTC Inspector of their concern of staff not reading all of their assessment notes when put into resident charts.

In an interview with the DOC and Resident Care Co-ordinator (RCC), they confirmed that if the BSO staff verbally communicated any information to the staff, they would document the name of the staff member and what was communicated in their notes. Review of the BSO assessment notes for the resident did not identify any documentation to demonstrate that the resident's chewing difficulties and history of aspiration was communicated verbally to front line staff.

Interview with PSW #304 confirmed that they were not aware of the resident's history of choking prior to admission or specific eating habits.

The DOC and RCC confirmed that the information regarding the resident's history of choking and eating habits was not communicated to staff; therefore, the staff did not collaborate in the assessment of the resident's eating risks. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure that the home's nutrition and hydration program included the implementation of interventions to mitigate and manage every resident's risks related to nutrition care and dietary services and hydration. This shall include the inclusion of all pertinent and relevant information obtained upon admission and throughout ongoing assessments in the residents' documented plans of care, and communication of this information to front line staff.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #001 experienced, the scope of one isolated incident, and the fact that the Licensee does not have a history of non-compliance in r. 68 (2) (c) related to the implementation of nutritional interventions.

The licensee failed to ensure that the home's nutrition and hydration program included the implementation of interventions to mitigate and manage resident #001's risks related to nutrition care and dietary services and hydration.

On an identified date in 2016, resident #001 deceased due to aspiration of food.

Interview with resident #002 on September 1, 2016, confirmed that resident #001 had identified behaviours related to food consumption. PSW #304 also confirmed these behaviours.

Review of the resident's health file identified the CCAC admission report in which information was identified regarding the resident's specific eating habits and history of choking. This included the need for the resident to be supervised closely.

Resident #001's documented plan of care, which front line staff use to direct care, indicated that the resident was on a regular diet, and it included specific interventions for staff to follow regarding the resident's diet.

Review of the RD's initial assessment completed in 2016, documented a specific intervention for the resident; however, interview with the RD and NSS confirmed that the resident's plan of care did not include the other necessary interventions recommended in the CCAC report to mitigate the resident's risk of choking. The RD confirmed that this information should have been conveyed onto the resident's plan of care and initiated by staff.

This information was confirmed with the DOC and RCC. The home did not implement interventions to mitigate and manage resident #001's choking risk. (586)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

Service Area Office /
Bureau régional de services : Hamilton Service Area Office