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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 22, 2017	2017_558123_0011	015083-17	Resident Quality Inspection

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. BOX604 SIMCOE ON N3Y 4L8

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

MELODY GRAY (123), AILEEN GRABA (682), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 13, 14, 17, 18, 19, 20 & 21, 2017.

Concurrent inspections completed during the inspection:
Critical Incident #011832-17 related to resident to resident alleged abuse
Critical Incident #026440-16 related to resident fall
Critical Incident #031331-16 related to medication error
Critical Incident #033030-16 related to resident fall
Critical Incident #030907-16 related to resident fall
Complaint #015364-17 related to alleged verbal abuse
Complaint #024466-16 related to resident care

During the course of the inspection, the inspector(s) spoke with Residents, family members, personal support workers (PSWs), registered staff, the Registered Dietitian, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Resident Care Coordinators, the Special Projects Nurse, the Director of Care (DOC) and the Administrator.

Inspectors toured the home, reviewed residents' records, reviewed the home's records including policies and procedures, observed infection prevention and management practices and reviewed the medication management system.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
3 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	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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The record of resident #013 was reviewed. The plan of care identified that they required extensive assistance of one staff to assist in choosing clothing and dressing. One staff was to assist in all aspects of morning and night care. On an identified date in June, 2017, documentation related to an investigation the home completed was reviewed and identified that PSW #113 did not follow the plan of care and assist the resident with undressing and getting dressed after the resident requested assistance.
The Director of Care (DOC) was interviewed and stated that although the resident was often capable of undressing and their plan of care identified they required assistance from the front line staff. The DOC confirmed that care related to dressing was not provided by PSW #113 to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plans of care of all residents is provided to the residents as specified in the plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

The record of resident #011 was reviewed and it was noted that the resident fell from a PASD on an identified date in October, 2016. The resident was sent to hospital for further assessment and there were no injuries from the fall identified. The plan of care indicated that the resident walked with an assistive device and the assistance of one to two persons. The progress note of an identified date in October, 2016, indicated that the resident was not walking well due to increase pain; however did not identify the intervention that was put in place was the identified PASD.
The DOC was interviewed and stated the resident was in an identified PASD due to increase pain and unsteady gait and they fell from the PASD. They also reported that it was the home's expectation that registered staff would document in a progress note why the resident was positioned in the PASD and what alternatives were trialed prior to using that PASD. The DOC confirmed that the use of the PASD was not documented in the resident's plan of care as a PASD. [s. 33. (3)]

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 a Personal Assistance Services Device (PASD) described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The record of resident #030 was reviewed and it was noted that on an identified date in September, 2016, the physician ordered an identified medication to be administered once daily. The order was signed by the physician the following day. Due to multiple factors, the medication was discontinued in error and the resident did not receive the medication for more than one month. The resident developed an identified condition and was admitted to the hospital on an identified date in October, 2016.
The Critical Incident report and the home's records were reviewed and included information as above.
The DOC was interviewed and confirmed resident #030 did not receive the identified medication according to the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Zero Tolerance of Abuse and Neglect", # A-74, revision date: February, 2013, identified that," in any case of abuse, (alleged or suspected), the employee(s) witnessing and or having knowledge of the incident shall verbally report the incident immediately to the immediate supervisor who will report information to the Administrator/Director of Nursing and Personal Care. The Administrator would comply with the mandatory reporting requirements of the Long Term Care Homes Act and Regulation by notifying the Director of any and all alleged abuse."

On an identified date in July, 2017, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to alleged abuse of a resident by a staff member.

The Administrator and the DOC were interviewed and reported that this allegation was reported to the DOC and the Resident Care Coordinators (RCCs) on an identified date in June, 2017, by registered staff #112 who witnessed the alleged incident between resident #013 and PSW #113.
registered staff #112 was interviewed and they stated they reported the incident to the charge nurse, registered staff #114. Registered staff #114 was interviewed and stated that this incident was reported but they did not realize that they were to notify the DOC immediately. The home started an investigation the following day; however, the Administrator and the DOC confirmed that a Critical Incident System (CIS) report was not submitted to the MOHLTC Director as required by the home's policy. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

A review of the Resident Council Minutes from February to June, 2017, identified that the licensee did not respond in writing to the Resident Council within ten days of receiving the following concerns or recommendations:
i. During the meeting of February, 2017, a concern regarding whether the home was going to have a hearing aid clinic.
ii. During the June, 2017, meeting, a recommendation that a planter in an identified home area needed to be re-stained.

The Program and Volunteer Supervisor was interviewed and confirmed that the home did not respond in writing within ten days to the above concerns. [s. 57. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3).

A review of the Resident Council Minutes identified that the 2016 satisfaction survey results were not made available or reviewed with the Residents' Council. This was confirmed during interview by the Program and Volunteer Supervisor. [s. 85. (4) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug that was to be destroyed was not a controlled substance, it was done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing.

Registered staff #102 was interviewed and reported that where drugs that are to be destroyed are not controlled substances, pharmacy staff is present and a member of the registered nursing staff appointed by the Director of Nursing and Personal Care is not present. This was confirmed during interview with the Administrator. The Administrator further indicated that the home's pharmacy service provider was immediately contacted and informed that one member of the registered nursing staff appointed by the Director of Nursing and Personal Care would participate in the destruction of all drugs which are not controlled substances. [s. 136. (3) (b)]

Issued on this 25th day of August, 2017

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

Original report signed by the inspector.