Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2020	2020_556168_0002	015567-19, 020428-19, 021952-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of Norfolk County
12 Gilbertson Drive SIMCOE ON N3Y 4N5

Long-Term Care Home/Foyer de soins de longue durée

Norview Lodge
44 Rob Blake Way SIMCOE ON N3Y 4N5

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

LISA VINK (168)

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): January 23, 24, and 27, 2020.

This Critical Incident Inspection was conducted related to the following log numbers:
015567-19 - related to falls prevention and management;
020428-19 - related to falls prevention and management; and
021952-19 - related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Supervisor of Nursing and Personal Care, registered nurses (RN), registered practical nurses (RPN), personal support workers and residents.

During the course of the inspection the inspector observed the provision of care and services and reviewed clinical records including but not limited to clinical health records, training records, policies and procedures and incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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)**

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	Légende 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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #011 was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed related to safety considerations.

A review of the clinical record identified that resident #011 had a history of falls.
Progress notes reviewed from early October 2019, until a second fall in October 2019, identified that the resident had specific responsive behaviours.
An Occupational Therapy note, dated in October 2019, identified that the resident required a mobility aide an ongoing basis now, according to the registered staff.
The resident sustained a fall, without injuries, three days later and the clinical record noted that the resident was more confused during the shift of the fall and not aware of their limitations. The documented action to prevent recurrence was to continue to monitor.
A Resident Assessment Protocol, completed six days later, identified that the resident now required a level of assistance with transferring, dressing and toilet use, an increase in assistance required from the past quarter.
A progress note, the following day, noted that the resident demonstrated responsive behaviours and had to be reminded to remain in a position for their safety.
The resident sustained a fall eight days later, from a mobility device, which resulted in an injury.
A review plan of care, related to falls, included some falls prevention interventions prior to the identified fall; however, additional interventions were not implemented to address the safety considerations with the change in needs related to the change in level of assistance with activities of daily living and behaviours.
Additional interventions were implemented after the identified fall.
Interview with the Supervisor of Nursing and Personal Care, following a review of the clinical record, confirmed it was the expectation that when the resident had a change in needs they would be reassessed and changes made to the plan of care.

The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. The licensee failed to ensure that resident #010 was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to pain management.

According to the clinical record resident #010 sustained a fall and injury on an identified date in August 2019, that was managed with interventions, which included the use of a device.
Following the injury the resident reported complaints of pain and was able to rate their pain on a scale according to the pain scores recorded.
The electronic Medication Administration Record (eMAR), for August 2019, was reviewed and identified that the resident was prescribed a routine over the counter analgesic four times a day and following the fall received an order for additional analgesic every four hours as needed for pain.
A progress note, dated three days after the fall, noted resident was in pain when awake and to consider asking physician for continual pain medication instead of as needed medication.
i. The eMAR later that day noted, the resident was administered the as needed medication when they identified pain. The medication was noted to be ineffective a few hours later, as recorded by RN #108. RN #108 administered the resident their routine analgesic as prescribed when the resident reported pain. The RN also administered the routine dosage of analgesic as prescribed approximately four hours later and the as needed analgesic, when the resident reported pain. The analgesic was identified to be effective the following shift.
Interview with RN #108, following a review of the clinical record, identified that they did not recall the shift in question; however, communicated that ideally if pain was not managed they would administer another as needed analgesic medication, if prescribed, or contact the physician for direction.
ii. The eMAR noted that, eight days later, the resident was administered the as needed analgesic when they reported pain, they also received their routine analgesic that morning. A progress note, written a few hours later, noted that the analgesic was ineffective by RPN #109. No additional as needed analgesic was administered. The resident was administered their routine analgesic, as prescribed on two occasions later in the day, when pain was identified. At bedtime, the resident reported their pain level to be more controlled. The progress notes nor eMAR included additional interventions to manage pain.
Interview with RPN #109, following a review of the clinical record, could not recall the shift in question; however, confirmed that follow up action was not taken and noted that they usually evaluate the effectiveness of as needed analgesic half to one hour after administration and would take action if not effective.
iii. The eMAR noted that on the following day, the resident was administered their as needed analgesic and another as needed analgesic when they reported pain. The medication was noted to be ineffective, a few hours later, by RPN #110. RN #110

administered the resident their routine analgesic as prescribed and as needed analgesic, when they reported pain.
Later on the evening shift, the physician was contacted, by RPN #111 regarding the resident's pain and an order was received to increase the dosage of as needed analgesic.
Interview with the DOC and Supervisor of Nursing and Personal Care, following a review of the clinical record, confirmed the examples identified above, according to the documentation, where the resident had a change in care needs, related to their pain and the expectation that staff would have taken action to manage this need.

The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed related to pain management. [s. 6. (10) (b)]

3. The licensee failed to ensure that resident #012 was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed related to safety considerations.

A review of the clinical record identified that resident #012 had a history of falls and responsive behaviours.
Progress notes included a fall with injury in November 2019, for which the resident was sent to the hospital for treatment.
The resident returned to the home and was assessed to require additional staff assistance for activities of daily living and utilized a mobility aid.
A progress note, on an identified date in December 2019, identified that the resident was alert and demonstrated a responsive behaviour. They were transferred to a different position and taken to breakfast.
A progress note, thirteen days later, by RPN # 113, identified that the resident demonstrated a responsive behaviour through the shift, that they were restless and refused fluids.
A progress note, the following day, identified that the resident demonstrated a responsive behaviour at the beginning of the shift. Analgesic was given but they continued to demonstrated the behaviour. A visitor arrived and sat with resident. There were no further issues that shift.
A progress note, the following day, identified that the resident sustained a fall. They were assessed and no injuries were noted. Following this fall staff initiated a specific falls prevention intervention.
A review plan of care, related to falls, included some falls prevention interventions prior to the second fall; however, additional interventions were not implemented to address the

safety considerations with the change in needs.
Interview with RPN #113 confirmed that they did not initiate a specific falls prevention intervention or other measures when the resident was observed to demonstrate the behaviour.
Interview with the Supervisor of Nursing and Personal Care, following a review of the clinical record, confirmed it was the expectation that when the resident had a change in needs they would be reassessed and changes made to the plan of care.

The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

Issued on this 28th day of January, 2020

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

Original report signed by the inspector.