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
Apr 26, 2021	2021_689586_0015	022735-20, 001761-21	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

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): April 19, 20, 21 and 22, 2021.

Long-Term Care Homes (LTCH) Inspector Jobby James was present and shadowing during this inspection.

The following Critical Incident System (CIS) inspections related to fall prevention and management were completed:
001761-21 (CIS #M624-000001-21); and,
022735-20 (CIS # M624-000018-20).

During the course of the inspection, the inspector(s) spoke with the Manager of Nursing and Personal Care (MNPC), Supervisor of Nursing and Personal Care (SNPC), Physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and housekeeping staff.

During the course of the inspection, the inspector(s) completed an Infection Prevention and Control (IPAC) Assessment, observed resident care and reviewed resident health records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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. (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 has failed to ensure that a resident was provided care as per the plan of care.

A resident's written plan of care directed staff to ensure there was a specific falls intervention in place at all times when the resident was in bed.

The resident experienced a fall and sustained a significant injury.

Registered staff, who responded to the incident, noticed that the specific fall intervention was not in place at the time of the fall, as per the plan of care. This was confirmed by the MNPC.

Not applying the specific fall intervention as per the plan of care may have contributed to the resident sustaining significant injury.

Sources: CIS report, resident clinical health record, Coroner's Report and interviews with staff. [s. 6. (7)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

The home's policy 'Personal Protective Equipment - Gowns' identified that when gowns were used, they were to be used only once and discarded into appropriate receptacles.

On one specific home area, used cloth isolation gowns were observed to be hung either on hooks inside the room, or on the outside door handle, of three resident rooms.

The staff and essential visitors did not discard the gowns as required. This was confirmed by the DOC.

Sources: The home's policy 'Personal Protective Equipment - Gowns' (dated May 3, 2018), observations and interviews with the DOC. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.