Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Original Public Report

Report Issue Date: July 31, 2023

Inspection Number: 2023-1619-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of Norfolk County

Long Term Care Home and City: Norview Lodge, Simcoe

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.08.01 13:21:02 -04'00'

Additional Inspector(s)
Julie Lampman (522)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17, 18, 19, 20, 21 and 24, 2023.
The inspection occurred offsite on the following date(s): July 25, 2023.

The following intake(s) were inspected:

- Intake: #00011581 CI #M624-000019-22 related to Resident Care and Support Services
- Intake: #00016329 CI #M624-000026-22 related to Medication Management
- Intake: #00016932 CI #M624-000028-22 related to Medication Management
- Intake: #00020760 CI #M624-000004-23 related to Falls Prevention and Management
- Intake: #00090857 a complaint related to Residents' Rights and Choices
- Intake: #00090925 a complaint related to Residents' Rights and Choices
- Intake: #00091429 a complaint related to a Safe and Secure Home.

The following intake(s) were also completed in this inspection:

- Intake: #00004547 CI #M624-000013-21 related to Falls Prevention and Management
- Intake: #00002105 CI #M624-000015-22 related to Falls Prevention and Management
- Intake: #00022167 CI #M624-000006-23 related to Falls Prevention and Management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A) A resident's SDM had not been made aware of multiple safety incidents involving the resident and their personal assistive device.

The Manager of Nursing and Personal Care (MNPC) acknowledged the resident's SDM was not informed of the specific incidents which occurred, and should have been. The MNPC stated they followed up with the registered staff member and informed them that a SDM was to be notified of any safety incidents involving a resident.

B) The home's Assistive Devices-Safety Assurance Program policy noted residents who exhibited unsafe techniques with a particular assistive device would be asked to participate in a screening developed and administered by Norview Lodge. Residents who were unsuccessful in passing could ask for a referral to the Occupational Therapist (OT) for an assessment and training of the assistive device.

A resident's SDM requested to have an independent OT complete an assistive device assessment on a resident at the SDM's cost. The home declined the SDM's request indicating that the resident's history indicated they posed a potential risk to others.

The MNPC stated that the resident did not have an assistive device screening, or a formal OT assessment completed after an incident. The MNPC acknowledged that the resident's SDM had requested that the resident have an independent OT assessment completed, which the home had declined.

Sources: A resident's clinical record, a complaint from a resident's SDM, the home's complaint response letter to a resident's SDM, the home's policy, and interviews with the MNPC and other staff. [522]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred should have immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rational and Summary
A Critical incident (CI) submitted by the home documented that a resident sustained an injury and a significant change in their health status related to an incident of improper care by a staff member.

A Supervisor of Nursing and Personal Care (SNPC) said they were aware of the incident on a later date and acknowledged that an incident of improper care should be reported immediately. Not reporting certain matters to the Director within the required time frame posed a minimal potential risk.

Sources: A Critical Incident System report, a resident's clinical records, and interviews with a SNPC and other staff. [524]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rational and Summary
A Critical incident (CI) submitted by the home documented that a resident sustained an injury and a significant change in their health status during a transfer in their assistive device. A Personal Support Worker (PSW) was present during the transfer.

A Supervisor of Nursing Personal Care acknowledged the resident had sustained an injury while being transferred in their assistive device by a staff member and had not followed the home's policy.

Sources: A Critical Incident System (CIS) report, the home's policy, a resident's clinical records, and

interviews with a SNPC and other staff. [524]

WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's medication management system policy related to medication checks for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

The home's policy stated that when a resident was ordered a specific drug administration system staff were to document twice daily in the electronic Medication Administration Record (eMAR) under a non-medication eMAR order that the medication system was intact on the days in between medication application and removal.

Rationale and Summary
A Registered Practical Nurse (RPN) discovered that a resident's medication was missing. Upon investigation it was determined that twice daily checks of the medication had not been completed and a non-medication eMAR order of the checks had not been entered into the resident's eMAR .

A Supervisor of Nursing and Personal Care (SNPC) stated pharmacy was responsible to enter checks for the medication in the eMAR and registered staff did not indicate that the medication checks were not included in the resident's eMAR when the order was processed.

Sources: Review of a CIS, a Medication Incident Report, a resident's clinical record, the home's policy, and interviews with a SNPC and other staff. [522]

WRITTEN NOTIFICATION: Resident Records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
A resident's substitute decision-maker (SDM) had made a complaint to the home regarding the resident's personal assistive device.

The Complaint Response Letter from the home to the resident's SDM, stated that on a number of occasions, the resident had unsafe incidents with their assistive device. There was no record in resident's progress notes of an incident on a specific date.

The Manager of Nursing and Personal Care (MNPC) acknowledged there was no documentation in resident's progress notes regarding the incident with their assistive device on a specific date and should have been.

Sources: Review of a complaint from the resident's SDM, the home's complaint response letter to the resident's SDM, the resident's clinical record and interviews with the MNPC and other staff. [522]