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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 31, 2024
Inspection Number: 2024-1619-0001
Inspection Type: Critical Incident
Licensee: The Corporation of Norfolk County
Long Term Care Home and City: Norview Lodge, Simcoe

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2024.02.09 12:51:13 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 22, 23, and 25, 2024

The following intakes were inspected:
Intake: #00098402 - CIS #M624_000022-23: Related to resident care and support services
Intake: #00101682 - CIS #M624-000029-23: Related to falls prevention and management

The following intakes were completed in the inspection: Intake #00097731, CIS #M624-000020-23, Intake #00098037, CIS #M624-000021-23 and Intake #00099276, CIS #M624-000024-23, related to the falls prevention and management program.

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident;

The licensee failed to ensure that appropriate action was taken during the homes critical incident investigation process.

Rationale and Summary:
A Critical Incident Report (CIS) was submitted for the improper/incompetent treatment of a resident that resulted in harm to the resident.

The Supervisor of Nursing and Personal Care reported that a staff member provided improper/incompetent care to a resident which resulted in injury to the resident, but acknowledged that they did not speak with the staff member regarding the incident.

The homes Administrator stated that follow-up with the staff member involved in the incident was expected as part of the homes investigation process and acknowledged that this did not occur in this situation.

As a result of not ensuring that follow-up occurred with the staff member involved in the incident, there was risk that appropriate corrective action was not taken to prevent reoccurrence.

Sources: CIS:M624-000022-23, the homes investigation notes, and interviews with the Supervisor of Nursing and Personal Care and the Administrator.

[741071]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that safe techniques were used when positioning and providing care to a resident.

Rationale and Summary:
It was documented that while receiving care, a resident fell and was injured.

The Supervisor of Nursing and Personal Care acknowledged that at the time of the fall, the staff member was not following the resident's plan of care or the home's expectations for safe care and positioning.

The resident fell and was injured as a result of failing to ensure that safe techniques were used during their care and positioning.

Sources: Resident's Progress Notes and interview with the Supervisor of Nursing and Personal Care.

[741071]