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: April 10, 2024

Inspection Number: 2024-1619-0002

Inspection Type:
Proactive Compliance Inspection

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: 2024.04.11 12:20:31 -04'00'

Additional Inspector(s)
Melanie Northey (563)
Brandy MacEachern (000752)
Neelam Patel (000814) was also present for the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 20 - 22 and 25 - 27, 2024

The following intake was inspected:

- Intake: #00111521 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care.

Rationale and Summary:

The care plan for the resident documented conflicting interventions related to a care area.

Direct care staff and the resident stated the correct care was being provided despite the inconsistency with the care plan.

Staff acknowledge that the care plan was not clear and updated the care plan to reflect the correct interventions required for the care area.

There was no impact to the resident although the inconsistency posed a risk that improper care could be provided.

Sources: Resident record review, observations, and resident and staff interviews.

[563]

Date Remedy Implemented: March 26, 2024

WRITTEN NOTIFICATION: Right to Quality Care and Self-Determination

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of

care, in accordance with that Act.

The licensee failed to ensure that every residents right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

Rationale and Summary:
Inspector #741071 observed a registered staff member leave a medication cart to deliver medications to three residents in a dining room while leaving the laptop on the medication cart open to the resident's electronic medication administration record (eMAR). During this time period, a resident was seated across the hall from the medication cart and a visitor spoke to Inspector #741071, who was standing across from the medication cart.

The registered staff acknowledged that the expectation was for the screen not to be visible.

There was risk that residents' personal health information was not protected when their eMAR's were not closed as required.

Sources: Observations and interview with staff.

[741071]

WRITTEN NOTIFICATION: Retraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training

under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that all staff at the home received annual training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary:
During a record review of eight different Surge training reports for the year of 2023 in the home, it was noted that seven of the modules were completed by 231 staff, while the training on the home's policy to promote zero tolerance of abuse and neglect of residents was completed by 230 staff members.

In an interview with the DOC, they informed that one staff member had been missed in the system for this module and therefore did not receive their annual training as expected for the year of 2023, on the home's policy to promote zero tolerance of abuse and neglect of residents. Additionally, the home's policy titled Zero Tolerance of Abuse and Neglect of Residents stated that all staff would receive education and training annually through the course of their employment, regarding the policy.

There was a risk that the staff member would not be aware and up to date on the home's policy to promote zero tolerance of abuse and neglect of residents, when they did not receive this annual training.

Sources: The long-term care home's policy to promote zero tolerance of abuse and neglect of residents, Surge training reports and staff interviews.

[000752]

WRITTEN NOTIFICATION: Food and Fluid Temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

Rationale and Summary:

During a record review of Meal Service Temperature Records for the month of March 2024 on one of the home areas, it was noted that for fifteen different meal services there were no food temperatures recorded. The home's Dining Room Meal Service-Nutrition Services Role Policy stated that during a meal service, the Dietary Aide shall take and record the temperature of the food items and re-therm or cool if needed.

The Supervisor of Nutrition Services reviewed Temperature Records for the month of March 2024 with Inspector #000752, and they advised that food temperatures had not been completed as expected.

There was a risk that food and fluids would not have been served at a temperature that was both safe and palatable to the residents when temperatures were not taken and recorded during fifteen different meal services on the home area.

Sources: Staff interviews, Meal Service Temperature Records for the month of

March 2024, Dining Room Meal Service-Nutrition Services Role Policy.

[000752]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that their drug destruction and disposal policy provided for any controlled substance that was to be destroyed and disposed of shall be stored separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

Rationale and Summary:
During a record review of the home's drug destruction and disposal policy, it was identified that the registered staff were to notify the Supervisor of Nursing and Personal Care when a controlled substance had been discontinued. The Supervisor of Nursing and Personal Care would then pick up and/or registered staff would deliver to the Supervisor of Nursing and Personal Care and a double count with the registered staff would occur collectively. Access to the locked cabinet was only available to the Supervisor of Nursing and Personal Care and Manager of Nursing and Personal Care, who were Registered Nurses. The policy did not account for a

process that the registered staff would follow when a Supervisor of Nursing and Personal Care was not present in the home.

Staff advised that on evenings and weekends, controlled substances for destruction remained in the medication carts, with substances that were available for administration to residents, until the nursing supervisor returned.

There was a risk to residents that administration of a controlled substance that was intended for destruction and disposal could have occurred, when the home's policy and process did not ensure that for any controlled substance that was to be destroyed and disposed of was stored separate from any controlled substance that was available for administration to a resident, at all times.

Sources: The home's drug destruction and disposal policy and staff interviews.

[000752]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The Licensee has failed to ensure that the homes Continuous Quality Improvement (CQI) Initiative Report included the requirements outlined in section 168 (2) 5 of the Ontario Regulations 246/22.

Rationale and Summary:
The DOC verified that the CQI Initiative Report posted on their website was the homes 2022/2023 report and acknowledged that the report did not include the requirements outlined in legislation.

There was no risk to the residents as a result of the non-compliance.

Sources: Continuous Quality Improvement Initiative Report 2023/2024 and interview with the DOC.

[741071]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The Licensee has failed to ensure that the homes CQI Initiative Report contained a written record of the requirements outlined is section 168 (2) 6 of the Ontario Regulations 246/22.

Rationale and Summary:
The DOC verified that the CQI Initiative Report posted on their website was the homes 2022/2023 report and acknowledged that the report did not include the requirements outlined in legislation.

There was no risk to the residents as a result of the non-compliance.

Sources: Continuous Quality Improvement Initiative Report 2023/2024 and interview with the DOC.

COMPLIANCE ORDER CO #001 Security of drug supply

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) The identified registered staff members will be provided training on expectations related to locking the medication cart.

B) Keep a written record of the training provided, the dates the training occurred, the names of the staff members who completed the training and the name of the person who provided the training.

C) The DOC or designate will complete an audit once weekly, during a specified time, on each home area, to ensure medication carts are locked when not in use. Audits will continue until an Inspector has complied the order.

D) Maintain a record of the dates, times and locations of the audits, name of staff member(s) completing the audits, audit findings, and any corrective measures taken in relation to the findings of the audits.

Grounds

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply in the medication cart, when the cart was not in use.

A. Rationale and Summary:
Inspector #000752 observed a resident open the drawer of an unattended medication cart, look at medications within the cart, then close the drawer.

A registered staff member came out of a different resident's room, advised that they had heard the medication cart drawers opening and acknowledged that the cart was not locked as expected. They explained that they had locked the cart prior to entering a resident's room, but they were unsure why the lock did not engage.

The home's Medication Cart Policy additionally stated that the medication cart was to be locked at all times when not in use.

There was a risk that the resident could have taken a medication that was not intended for them, when the medication cart was not locked, and they had access to the drugs.

Sources: Observations, staff interview and medication cart policy.

[000752]

B. Rationale and Summary:
Inspector #741071 observed a registered staff member leave a medication cart unlocked and unattended three times to deliver medications to residents in a dining room.

The registered staff member acknowledged that the expectation was for the cart to be locked.

There was risk of the medication cart being accessed by residents because the cart was left unlocked while unattended.

Sources: Observations and interview with staff.

[741071]

This order must be complied with by May 15, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.