Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
May 13, 2019	2019_514566_0007	022988-17, 002632-18, 023338-18, 033305-18	Critical Incident System

Licensee/Titulaire de permis

Norwood Nursing Home Limited
122 Tyndall Avenue TORONTO ON M6K 2E2

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

Norwood Nursing Home
122 Tyndall Avenue TORONTO ON M6K 2E2

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

ARIEL JONES (566)

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): Apr. 17, 24, 25, 26, 30, May 1, 2 and 6, 2019

**The following critical incidents (CIS) were inspected during this inspection:
Log #022988-17 / CIS #2201-000004-17, Log #002632-18 / CIS #2201-000002-18, and Log #033305-18 / CIS #2201-000005-18 related to responsive behaviours; and
Log #023338-18 / CIS #2201-000003-18 related to falls prevention and improper care.**

Complaint inspection report number #2019_514566_0008 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered nursing staff (RN/RPN), personal support workers (PSW), and residents.

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, provision of resident care, reviewed residents' health care records, investigation notes, and relevant home policies and procedures.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #006.

A critical incident system (CIS) report was submitted to the MOHLTC on an identified date in August 2018, with regards to a fall that caused an injury for which resident #006 was taken to hospital. The report detailed that while resident #006 was being assisted by staff in their identified mobility device, the resident fell from the device and sustained an identified injury.

A review of the home's investigation notes into the incident determined that an identified support panel on resident #006's mobility device had come off while the resident was being assisted by PSW #106, causing both the resident and mobility device to overturn.

According to PSW #106's written statement following the incident, they were assisting resident #006 at the time of the incident and were about to adjust their mobility device into a more supportive position when all of a sudden the resident fell onto the floor landing on an identified body part. The nurse was immediately called for help and the resident was assessed and sent to hospital.

A review of resident #006's progress notes indicated that the resident was transferred to hospital immediately following the incident and returned later on the same date with an identified injury.
A review of resident #006's plan of care for an identified time period indicated that the resident required an identified mobility device with assistance from staff, and that the resident was at risk for falls.

During an interview with PSW #106, they indicated that they were not the usual caregiver for resident #006 at the time of the incident but were familiar with the resident and assisting them using their mobility device. PSW #106 indicated that the resident was to be in an identified position in their mobility device while being assisted. At the time of the incident, PSW #106 indicated that they were assisting resident #006 from one home area to another when all of a sudden the resident fell forward onto the floor. The PSW indicated further that the resident's mobility device was not in the identified safe position and that they had not realized that an identified support panel was not properly fastened. PSW #106 confirmed that they did not check that the support panel was properly secured before assisting the resident.

During an interview, DOC #100 indicated that according to video footage, the resident's mobility device was in a safe position while resident #006 was being assisted by PSW #106 but that the staff did not notice that the identified support panel had come loose and that it was totally off when the resident fell from the mobility device. DOC #100 confirmed

that the involved staff member received disciplinary action related to the incident which resulted in an injury to resident #006. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 14th day of May, 2019

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

Original report signed by the inspector.