



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection prévue
le Loi de 2007 les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016;	2015_322156_0023 (A1)	034254-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF NORFOLK COUNTY
50 Colborne Street South SIMCOE ON N3Y 3H3

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

NORVIEW LODGE
44 ROB BLAKE WAY P. O. BOX 604 SIMCOE ON N3Y 4L8

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



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CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This order compliance date was changed based on a request by the Administrator of the home. The request was to extend the date by two weeks due to the inability to have all staff educated due to previously scheduled education dates by the home.

Issued on this 25 day of February 2016 (A1)

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

Original report signed by the inspector.



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CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 10, 11, 14, 15, 16, 17, 21, 22, 2015, January 5, 6, 7, 8, 13, 2016

Inspections completed simultaneously with the RQI inspection included: Critical Incident Reports 000077-14, 007098-14, 008066-14, 009746-14, 000027-15, 015121-15, 019764-15, 034068-15 and complaints 007224-15, 017109-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Acting Director of Care (ADOC), Facilities Services Supervisor, Resident Assessment Instrument (RAI) Coordinator, Resident Care Coordinator (RCC), Food Services Supervisor (FSS), Dietary aides, cooks, Personal Support Workers (PSW), registered staff, Registered Dietitian (RD), residents and families.

The following Inspection Protocols were used during this inspection:



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Contenance Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

11 WN(s)

5 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Bed rails



Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that where bed rails were used, that the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #012 was noted to have an assist bed rail in the 'up' position on the left hand side of the bed on December 16, 2015. The bed rail had not been assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #104 and the Acting DOC on the same date.

B) The bed of resident #013 was observed with staff member #106 having one quarter bed rail up on the left and an assist bed rail up on the right. Staff #106 was interviewed and reported that the resident used the rail on the left side of the bed for assistance with repositioning and used the one on the right to assist with transferring in and out of the bed. Resident #013 was interviewed and reported that they used the quarter rail to keep their pillow in place and used the assist rail to transfer in and out of bed. The resident's record was reviewed and the Resident Assessment for Bed Rails was completed for one bed rail on the left side of the bed. There was no assessment of the right bed rail found in the resident's record. The Resident Care Coordinator confirmed that the assessment was not completed for the bed rail on the right side of the resident's bed. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On December 16, 2015, the Facilities Services Supervisor confirmed that the home had not completed a bed entrapment audit since 2011 and all beds had been replaced since that time. Steps were not taken to prevent resident bed entrapment taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".



(A1)The following order(s) have been amended:CO# 001

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 where bed rails were used, that the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident and to ensure that where bed rails were used, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home policy Skin and Wound Care Program dated February 18, 2015, under "Treatment Plans for Different Wound Stages" indicated that for Stage 3 or 4 wounds, no tub baths were to be provided.

i) Resident #012 was noted on the wound assessments to have a Stage 3 wound on an identified area on two identified dates in November, 2015, three identified dates in December, 2015 and one identified date in January, 2016. Interview with PSW #110 on January 6, 2016 and supporting documentation on the Bath Record and Skin Checklist, confirmed that a tub bath was provided to the resident on these corresponding dates. Interview with the ADOC on January 6, 2016 confirmed that staff did not follow the home policy.

ii) Resident #015 was noted on the wound assessments to have a Stage 3 wound on an identified area in August, 2015. Interview with the RAI coordinator on January 8, 2016 and supporting documentation on the Bath Record and Skin Checklist confirmed that the resident received a tub bath on one identified date in August, 2015, three identified dates in October, 2015, three identified dates in November, 2015, and one identified date in December, 2015, while still having the stage 3 wound. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect



Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and to ensure that residents were not neglected by the licensee or staff as evidenced by:

A) The records of residents #208 and #209 and the home's records were reviewed. It was noted that in December, 2014, resident #208 and #209 were involved in an altercation which resulted in resident #209 sustaining physical injuries.

The Resident Care Coordinator (RCC) was interviewed and confirmed that the information contained in the residents' records and the home's records including the Critical Incident (CI) report was correct.

B) The records of residents #211 and #212 and the home's records were reviewed. It was noted that in April, 2014 residents #211 and #212 were involved in a physical altercation which resulted the resident #212 sustaining a large bruise.

The RCC was interviewed and confirmed that the information contained in the residents' records and the home's records including the CI report was correct.

C) The records of residents #204 and #210 and the home's records were reviewed. It was noted that in February, 2014 residents #204 and # 210 were involved in a physical altercation which resulted in resident #210 physical injuries.

The RCC was interviewed and confirmed that the information contained in the residents' records and the home's records including the CI was accurate. [s. 19. (1)]

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 residents were protected from abuse by anyone and to ensure that residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).

(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).

(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :



1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The resident's #211 and #212 and the home's records including the CI report were reviewed. It was noted that in April, 2014, residents #211 and #212 were involved in a physical altercation which resulted in resident #212 developing a bruise.

The Critical Incident report was submitted to the Director two days later by the RCC in April, 2014.

The RCC was interviewed and confirmed the accuracy of the documentation in the resident's record and the home's record and that the home did not immediately report the suspected abuse to the Director. [s. 20. (2) (d)]

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 a person who had reasonable grounds to suspect that any of the following occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care



Specifically failed to comply with the following:

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
- (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
- (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
- (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
- (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Resident #012 was noted to have multiple areas of altered skin integrity.

i) Interview with the RAI coordinator on January 5, 2016 confirmed that the home did not use a clinically appropriate assessment instrument on nine occasions to assess the resident's identified wound.

ii) Interview with the Acting DOC and Resident Care Coordinator on January 6, 2016 confirmed that the home did not use a clinically appropriate assessment instrument to assess the resident's other identified area with several separate areas of altered skin integrity.

B) Resident #014 was noted to have a stage two pressure ulcer on an identified area. Interview with the RAI coordinator on January 8, 2016 confirmed that the home did not use a clinically appropriate assessment instrument to assess the resident's wound on all occasions between July 28, 2015 - September 2, 2015.

C) Resident #015 was noted to have a stage three wound on an identified area since August, 2015.



Interview with the RAI coordinator on January 8, 2016 confirmed that the home did not use a clinically appropriate assessment instrument to assess the resident's altered skin integrity on January 7, 2016. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

A) Resident #014 was noted to have a stage two pressure ulcer on an identified area in July, 2015. The resident did not have their skin integrity re-assessed by a member of the registered nursing staff for two weeks in August 2015 as confirmed during interview with the RAI coordinator on January 8, 2016.

B) Resident #015 was noted to have a stage three pressure ulcer on an identified area in August, 2015. The resident did not have their skin integrity re-assessed by a member of the registered nursing staff from October 16 - November 8, 2015 and from December 21, 2015 - January 5, 2016 as confirmed during interview with the RAI coordinator on January 8, 2016. [s. 50. (2) (b) (iv)]

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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care



Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :



1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The record of resident #201 who was ambulatory with a walker was reviewed and it was noted that the plan of care was not based on an assessment of the resident's needs and preferences as it did not indicate the use of identified medical equipment. The home's records were reviewed and it was noted that in July, 2015 the resident was not provided with the required equipment. The resident fell while attempting to use the equipment and was transferred to the hospital. The resident suffered an injury as a result of the fall.

The RAI Coordinator was interviewed and reported that it is the home's expectation that residents were to be provided with the specified medical equipment when they were up and about throughout the home. Care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan was no longer necessary.

A) Resident #012 was noted to have had altered skin integrity. The documentation was unclear regarding when the resident's wound had healed; however, interview with registered staff #114 reported that the wounds had healed in November or December, 2015. The current plan of care on January 6, 2016, indicated that the resident had a stage two wound; the plan of care was not reviewed and revised when the resident's care needs had changed and care set out in the plan was no longer necessary.

B) Resident #014 was noted to have a stage two wound in July, 2015. The plan of care in place at the time did not include the resident's altered skin integrity and was not updated until September 2, 2015. On this date, the progress notes indicated that the resident's pressure ulcer had resolved with no subsequent changes to the resident's plan of care being made until November 30, 2015. The plan of care was not reviewed and revised when the resident's care needs changed or when care set out in the plan was no longer necessary as confirmed during interview with the RAI Coordinator on January 8, 2016.

C) Resident #015 was noted to have altered skin integrity with a stage three wound in August, 2015. The plan of care was not revised when the resident's care needs had changed until October 16, 2015, as confirmed during interview with the RAI coordinator on January 8, 2016. [s. 6. (10) (b)]



**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17.
Communication and response system**

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).

(b) is on at all times; O. Reg. 79/10, s. 17 (1).

(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).

(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).

(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).

(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, was available in every area accessible by residents.

It was identified that the home did not have a resident-staff communication and response system located in the chapel on the first floor lounge or in the secured outdoor areas used by residents. Interview with the Administrator confirmed that a communication and response system was not available in the identified areas, which residents accessed. [s. 17. (1) (e)]



WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:

2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council. Review of the Resident Council and Food Committee minutes as well as interview with the Nutritional Services Supervisor and the Programs/Volunteer Supervisor on December 15, 2015, confirmed that the Residents' Council did not review the meal and snack times. [s. 73. (1) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey



Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,

(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).

(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).

(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).

(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they documented and made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Review of the Resident Council minutes and interview with the Program/Volunteer Supervisor on December 15, 2015, confirmed that they failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints



Specifically failed to comply with the following:

**s. 101. (3) The licensee shall ensure that,
(c) a written record is kept of each review and of the improvements made in
response. O. Reg. 79/10, s. 101 (3).**

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of each review and of the improvements made in response to complaints.

The home's 2015 complaints record was reviewed. The home was requested to produce the written records of each quarterly review and the improvements made in response. The written records were not produced. The Administrator was interviewed and confirmed that the written records of each review and the improvements made in response were not available. [s. 101. (3) (c)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in
accordance with the directions for use specified by the prescriber. O. Reg.
79/10, s. 131 (2).**

Findings/Faits saillants :



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1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The record of resident #203 and the home's records were reviewed and it was noted that on an identified date in April, 2015, the resident's 0800 hours pain medication was found on their nightgown by their family member. The Resident Care Coordinator (RCC) was interviewed and confirmed that the medication was not administered to the resident in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]



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Issued on this 25 day of February 2016 (A1)

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

Original report signed by the inspector.



**Ministry of Health and
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Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la Loi de 2007 sur les
foyers de soins de longue durée, L.
O. 2007, chap. 8

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de
la performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : CAROL POLCZ (156) - (A1)

Inspection No. /

No de l'inspection : 2015_322156_0023 (A1)

Appeal/Dir# /

Appel/Dir#:

Log No. /

Registre no. : 034254-15 (A1)

Type of Inspection /

Genre d'inspection: Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Feb 25, 2016;(A1)

Licensee /

Titulaire de permis : THE CORPORATION OF NORFOLK COUNTY
50 Colborne Street South, SIMCOE, ON, N3Y-3H3

LTC Home /

Foyer de SLD : NORVIEW LODGE
44 ROB BLAKE WAY, P. O. BOX 604, SIMCOE,
ON, N3Y-4L8



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la Loi de 2007 sur les
foyers de soins de longue durée, L.
O. 2007, chap. 8

Name of Administrator / Bill Nolan
Nom de l'administratrice
ou de l'administrateur :

To THE CORPORATION OF NORFOLK COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :



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(A1)

The licensee shall complete the following:

1. Re-assess all bed systems using the Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".
2. Implement interventions to reduce or eliminate entrapment zones for those residents who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention in the residents' plan of care.
3. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
4. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
5. All health care workers shall receive education on the hazards of bed rail use.



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Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" developed by the U.S. Food and Drug Administration and adopted by Health Canada.

Resident bed systems were assessed for entrapment zone risks in 2011 as confirmed with the Facilities Services Supervisor on December 16, 2015 but that all beds had been replaced since that time and had not been assessed to date. Steps were not taken to prevent resident bed entrapment taking into consideration all potential zones of entrapment using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".

(156)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Mar 31, 2016(A1)



**Ministry of Health and
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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director



**Ministry of Health and
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603



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foyers de soins de longue durée, L.
O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25 day of February 2016 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** CAROL POLCZ - (A1)

**Service Area Office /
Bureau régional de services :** Hamilton