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

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Public Report

Report Issue Date: September 9, 2025

Inspection Number: 2025-1619-0005

Inspection Type:
Critical Incident

Licensee: The Corporation of Norfolk County

Long Term Care Home and City: Norview Lodge, Simcoe

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3, 4, 5, 8, 9, 2025

The following intake(s) were inspected:
-Intake: #00154634 - M624-000023-25 related to a choking incident.
-Intake: #00155059 - M624-000024-25 related to a fall.
-Intake: #00155452 - M624-000025-25 related to a fall.
-Intake: #00155629 - M624-000026-25 related to a fall.

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

Food, Nutrition and Hydration
Medication Management
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided with two nutritional interventions, as per their plan of care.

On a specific date staff did not provide a resident with an eating aid, as per their plan of care, which made it more difficult for the resident to self feed.

On another date it was noted in the clinical records that a resident was provided with an incorrect fluid thickness, which was not appropriate for their care needs.

Sources: Clinical records for a resident, an observation of meal service, and interviews with the Registered Dietitian and other staff.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that oxygen saturation readings and the administration of a medication to a resident were documented.

When a resident was documented as having difficulty breathing, staff did not consistently document their oxygen saturation levels. Also, staff did not document the administration of a medication, however, confirmed to an inspector that it was given.

A Supervisor of Nursing and Personal Care stated that all measurements of oxygen saturation levels were required to be documented in Point Click Care and that all medication administrations should be documented on the electronic medication administration record (eMAR).

Sources: Clinical records for a resident and interviews with a Supervisor of Nursing and Personal Care and other staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that a medication was not provided to a resident when it was not prescribed to the resident.

A Supervisor of Nursing and Personal Care stated that a medication was initially started for a resident under the medical directives of the home, however, when it was added to the resident's plan of care, and administered on multiple dates, the home was required to obtain a physician's order, but did not.

Sources: Clinical records for a resident, a home policy, and interviews with a Supervisor of Nursing and Personal Care and other staff.