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 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 20, 2016	2016_322156_0016	033087-16	Resident Quality Inspection

Licensee/Titulaire de permis

NORFOLK HOSPITAL NURSING HOME (THE)
365 WEST STREET SIMCOE ON N3Y 1T7

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

THE NORFOLK HOSPITAL NURSING HOME
365 WEST STREET SIMCOE ON N3Y 1T7

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

CAROL POLCZ (156), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 29, 30, December 1, 6, 7, 8, 9, 13, 2016

The following inspections were conducted simultaneously:
Complaint 032346-15 related to medication
Complaint 026508-16 related to meal service
Critical incident 025213-16 related to prevention of abuse

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSW's), dietary and housekeeping staff, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #004 was observed to have one bed rail in the raised position on identified dates in November and December, 2016.
i) The plan of care for this resident indicated under the focus of "falls" that the resident was at risk for falls and used one side bed rail up for transferring safety and to reposition in bed. The PASD bed rail was not noted under the focus of bed mobility for this resident.
ii) The PASD bed rail assessment dated July, 2016, indicated that the use of PASD bed rails was for unsteady gait and forgets ambulation device. This assessment did not include "uses bed rails for positioning and support".
iii) The bed rail safety analysis, indicated that the resident (not staff) had expressed a need for bed rails (for comfort, safety or repositioning).
iv) The admission note indicated that due to a past fall, staff were to ensure that the resident's unit was kept clutter free, that the call bell was within reach at all times, and that the resident used a bed rail for transfers.
v) Interview with the Nurse Manager on December 1, 2016, reported that the bed rail

was used to assist with turning and positioning and not a fall prevention strategy.
Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other as confirmed with the DOC on December 13, 2016. [s. 6. (4) (a)]

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

A) The most recent Minimum Data Set (MDS) assessment for resident #003 indicated that the resident was “occasionally incontinent” of bowels. The two previous MDS assessments, indicated that the resident was “continent” and going back another two quarters, the MDS assessments indicated that the resident was “occasionally incontinent” of bowels. Other MDS assessments going back a year indicated that the resident was “frequently incontinent”.
The plan of care for the resident indicated that the resident was “frequently incontinent” of bowels. The DOC confirmed on December 8, 2016 that the plan of care had not been updated when the resident’s care needs had changed.

B) Resident #040 was observed to be sitting in the dining room on an identified date in December, 2016, and it did not appear that the resident was mobile. The plan of care for this resident indicated that the resident "had been leaving the dining room, appeared overwhelmed and distracted by others, and once the resident leaves, it was difficult to get them to return". Interview with staff #101 and registered staff #104 on December 8, 2016, confirmed that the resident was no longer mobile and that the plan of care had not been updated when the resident's care needs had changed. [s. 6. (10) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the resident has been reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary, 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.

The home's Medication Administration policy and procedure was reviewed and indicated that staff were to "identify the total number of medications to be administered and give to the resident. Ensure that the resident takes all of the medication, and document on the eMAR as not administered ("N") if they don't. Click on the "Y" button on the eMAR for each medication administered and click Save".

The record of resident #051 was reviewed including the progress notes and the eMAR.
i) On an identified date in November, 2016, in the eMAR, there was no documentation at 1400 hours to indicate whether or not the resident received two identified medications. The spaces were blank.
ii) The progress notes were reviewed and it was noted on an identified date in November, 2016, that resident #051 was lethargic and did not take their medications. The progress notes noted that the resident's family member was contacted and informed that the resident did not take their medications the day before, until the afternoon. The eMAR documentation indicated that all the medications were given at the correct time.
The Nurse Manager was interviewed and confirmed that the staff were to complete a "yes" or "no" when the medication was administered as per the home's policies and procedures. The Nurse Manager also confirmed that some of the medications not administered in the morning of an identified date in November, 2016, would not be given along with additional doses of the same medications in the afternoon. The staff did not comply with the home's medication administration policies and procedures in that documentation indicated medications were administered in the morning when actually they were given in the afternoon according to interview and progress notes. [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 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, other safety issues related to the use of bed rails were addressed, including height and latch reliability.

At the time of the inspection, the home had stickers on the beds of residents #004 and #001 which indicated that the height and latch reliability of the bed rails had last been tested in 2012. The DOC reported that the home currently re-tested the height and latch reliability on an 'as needed' basis but regularly scheduled annual testing was not in place. Interview with the DOC on December 13, 2016 confirmed that the expectation of the home would be that the safety issues related to the use of bed rails were addressed, including height and latch reliability would be completed on an annual basis. [s. 15. (1) (c)]

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 where bed rails were used, other safety issues related to the use of bed rails were addressed, including height and latch reliability, to be implemented voluntarily.

WN #4: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

A) During the observed lunch meal on December 6, and 7, 2016, resident #042 was observed being served dessert prior to the completion of the main entrée.
B) On December 7, 2016, residents #041 and #042 were observed being served the dessert prior to the completion of the main entrée.
A review of the plans of care for these residents did not indicate that they had been assessed to receive dessert prior to the completion of the main entrée.
Several other residents were observed on both dates to receive their dessert prior to the completion of the main entree.
Interview with staff #101 on December 7, 2016, confirmed that the lunch meal was not served course by course. [s. 73. (1) 8.]

2. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

A) The plan of care for resident #040 indicated that staff were to provide extensive to total physical assistance, remaining with the resident throughout the meal. During the lunch meal observation on December 7, 2016, resident #040 was observed at the table with food in front of them for at least ten minutes until the PSW finished assisting another resident. The meal was served to the resident prior to someone being available to provide the necessary assistance.
B) Resident #005 was assessed by the RD as being at high nutritional risk and the plan of care for this resident indicated that staff were to provide constant encouragement, remaining with resident during meals; supervision to extensive physical assist.
On December 7, 2016 the lunch meal for this resident was served on the table at 1230 hours; however, the resident was not at the table until 1247 hours.
Residents who required assistance with eating or drinking were observed being served a meal prior to when someone was available to provide the required assistance. [s. 73. (2) (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 meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

WN #5: 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 :

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

The record of resident #050 was reviewed including progress notes; care plan and the Medication Administration Record (MAR) dated October and November 2015. The Nurse Manager confirmed and progress notes indicated that on an identified date in October, 2015, the staff did not monitor the resident taking their lunch time medications. The medications in yogurt were left at the bedside and the resident did not take the medications. The yogurt and medications were removed from the resident's room in the afternoon. The MAR was reviewed and it was noted that the identified lunch medications were recorded as having been given as ordered.
The progress notes on this date indicated that the medications that were to be given at lunch were not given as they were in the yogurt which was thrown out. The Nurse Manager was interviewed during the inspection and confirmed that the lunch time dose medications were not administered to resident #050 in accordance with the the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During the initial tour of the home on November 29, 2016, double toasters were observed plugged in on counters in the main and first floor dining rooms. When the inspector turned them on, they became hot. The inspector was also able to push the buttons on the machine which dispensed hot water, tea and coffee and hot steaming liquid was dispensed. This occurred on both floors. Residents were observed in the vicinity and no staff were present in dining areas.
The DOC toured the main and first floor dining rooms with inspector #123 and confirmed the hot water, coffee, and tea machines buttons were accessible and dispensed hot liquids when the buttons were pushed. The DOC reported and demonstrated that there was a metal sheet installed on the machines for staff to pull down and cover the buttons to limit residents' access to the buttons but this was not done. The DOC also confirmed that the toasters in both dining rooms became hot when turned on and that residents were observed in the vicinity with no staff present. The licensee failed to ensure that the home was a safe and secure environment for its residents. [s. 5.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policies and procedures Prevention of Abuse and Neglect, #II-b-59, revised September 30, 2010, and Staff Reporting and Whistle-Blowing Protection, #II-b-70 dated March 30, 2011, were reviewed. They included: The Long-Care Home Operator shall: Report to the Ministry of Health and Long-Term Care (MOHLTC) every suspected or confirmed incident of abuse. Also, any staff or board member who is aware of or suspects any of the following must report it as soon as possible in accordance with the reporting procedures in this policy: Abuse of a resident by anyone, or neglect of a resident by a staff member or board member of the home.

The home's records including Critical Incident report #2621-000006-16 were reviewed and it was noted that on an identified date in 2016, Personal Support Worker (PSW) #108 allegedly witnessed PSW #109 abuse resident #002. PSW #108 reported the alleged incident to the DOC on an identified date in 2016. The DOC reported the incident to the MOHLTC four days later.
PSW #108 was interviewed and confirmed that the alleged incident took place on an identified date in 2016, and that they reported it to the DOC five days later. The DOC was interviewed and confirmed that PSW #108 reported the alleged abuse on the identified date in 2016, and they reported the alleged incident to the MOHLTC on an identified date in 2016. The DOC confirmed that PSW #108 did not immediately report the the alleged abuse to the home and the home did not immediately report the incident to the MOHLTC as per the home's policies and procedures. [s. 20. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

The therapeutic menu for Tuesday, Day 17 for pureed textured diet indicated that the alternative choice for dessert was pureed pears. During the observed lunch meal on the main floor on December 6, 2016, the pureed pears as the alternative choice for dessert was not available as confirmed with staff #101. [s. 71. (4)]

Issued on this 12th day of January, 2017

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

Original report signed by the inspector.