Ontario

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 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

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 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Sep 19, 2019	2019_695156_0003	004601-18, 011644-18	Complaint

Licensee/Titulaire de permis

The Norfolk Hospital Nursing Home
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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 18, 23, August 12, 13, 14, 19, 20, 2019.

During the course of the inspection, the Inspector reviewed resident clinical records, the homes policies and procedures, the homes investigation notes and staff training records.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Registered nursing staff, PSW's (personal support workers), Physiotherapist, Physiotherapist Assistant, and the resident.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's right to ii. give or refuse consent to any treatment, care or services for which his or her consent required by law and to be informed of the consequences of giving or refusing consent, was respected and promoted. c. 8, s. 3 (1).

Resident #001 was admitted to the home in February, 2018.

All admission consents (8) were signed by the resident.

On an identified date in 2018, progress notes written by PSW #100 indicated that the resident refused an identified aspect of care. Several staff performed the aspect of care and the resident refused. Interview with PSW #100 confirmed that the resident was upset and had refused the identified aspect of care.

Interview with PSW #108 who was also present the day that the care was performed reported that they knew the resident refused.

Interview with PSW #101 and #107 confirmed that the staff were all aware that the resident had always refused the identified aspect of care.

The admission plan of care for the resident indicated that the resident refused the identified aspect of care; staff were to use a different approach to care.

In an interview with the Nurse Manager, they confirmed that staff were aware that the resident refused the aspect of care but that in 2018, staff performed the care which upset the resident.

The DOC reported that they were aware that the resident had refused the aspect of care and that this was a trigger for responsive behaviours for the resident.

The resident was interviewed by Inspector #156 on July 18, 2019, approximately one and a half years after the incident. The resident expressed fear and upset related to the incident. The resident stated that the staff had not performed this particular aspect of care on the resident since that one time.

The DOC confirmed that the resident had refused the aspect of care and therefore, did not consent to the aspect of care, however, staff continued. The licensee failed to ensure that the rights of resident #001 were fully respected and promoted in relation to their refusal of consent to the aspect of care. [s. 3. (1) 11.]

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 resident #001's right to ii. give or refuse consent to any treatment, care or services for which his or her consent required by law and to be informed of the consequences of giving or refusing consent, is respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of or is reported to the licensee was immediately investigated.

The home's policy "Zero Tolerance of Abuse and Neglect" Number l-a-30 dated January 31, 2013 under section two: reporting and notifications about incidents of abuse or neglect indicated that "to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC….management staff will report to the MOHLTC Director the results of every investigation the home conducts under this policy, and any action the home takes in response to any incident of resident abuse or neglect". Under section three: investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, indicated that the management staff must fully investigate the incident and complete the documentation of all known details of the reported incident. The Administrator or designate shall ensure that a copy of the documentation is stored within a secure area.

Resident #001 was admitted to the home in 2018. The progress notes on the same date, indicated that the resident refused an identified aspect of care.

The following day, the progress notes described an incident where the resident refused the aspect of care, however, several staff performed the care and the resident refused.

Additional documentation, written by the Nurse Manager indicated that the resident was expressing concerns and stating that they were abused. Interview with the Nurse Manager, stated that they had reported this to the DOC (to report to the Director).

Progress notes written by the DOC indicated that the resident was upset about the aspect of care performed the day before; notes indicated that the resident had placed a call to the Ministry of Health to report abuse.

Discussion with the DOC, indicated that they were unsure if they investigated the initial incident with the aspect of care as they were just getting to know the resident. The home did not have any documentation to support that an investigation into the incident had occurred. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of or is reported to the licensee was immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse that the licensee knows of or is reported to the licensee was immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #001 was admitted to the home in 2018. The resident acted on their own behalf and all consents (8) on admission were signed by the resident.

A) Progress notes in 2018 indicated that the resident refused an aspect of care, however, several staff had performed the care. The resident refused.

Additional documentation in 2018 written by the Nurse Manager indicated that the resident was expressing concerns that they were abused. Interview with the Nurse Manager stated that they had reported this to the DOC (to report to the Director).

In 2018, progress notes written by the DOC indicated that the resident was upset about the aspect of care performed the day before and was informed that the resident had placed a call to the Ministry of Health to report abuse.

Interview with the DOC confirmed that they were aware of the allegation but the incident was not reported to the Director. The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

B) In 2018, progress notes written by PSW #103 indicated that they were working with PSW #105 when resident #001 was requesting a bed pan. The notes indicated that the bed pan was removed half an hour later after several checks to see if the resident was ready to come off of the bed pan. Care was provided to the resident and it was noted that the resident had pain and altered skin integrity.

Progress notes on the same day, written by Physiotherapist Assistant #104 indicated that the resident reported that they were treated roughly. Interview with the staff, confirmed that they had written the progress note and stated that they had reported this to their supervisor, the Physiotherapist.

PSW #103 who no longer worked in the home was unavailable for an interview. PSW #105 who was referred to in the progress note written by PSW #103 reported that they were aware of an allegation about PSW #103 but did not hear the allegation directly from the resident and could not confirm the allegation.

Interview with the Physiotherapist reported that they were aware of the allegation and that they had a discussion about the progress note with the Physiotherapist Assistant. They reported that they had spoken to the Nurse Manager and/or the DOC about the allegation. The Physiotherapist reported that they thought it was dealt with as changes were made to the care plan after that which included that identified staff were not to provide care to the resident. The Physiotherapist was unsure if a CIS had been submitted.

Interview with the DOC confirmed that they were aware of the allegation but the incident was not reported to the Director. The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (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 the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

The home's policy "Zero Tolerance of Abuse and Neglect" Number l-a-30 dated January 31, 2013 under section two: reporting and notifications about incidents of abuse or neglect indicated that "to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC….management staff will report to the MOHLTC Director the results of every investigation the home conducts under this policy, and any action the home takes in

response to any incident of resident abuse or neglect". Under section three: investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, indicated that the management staff must fully investigate the incident and complete the documentation of all known details of the reported incident. The Administrator or designate shall ensure that a copy of the documentation is stored within a secure area.

In 2018, progress notes written by PSW #103 indicated that they were working with PSW #105 when resident (#001) was requesting a bed pan. The notes indicated that the bed pan was removed half an hour later after several checks to see if the resident was ready to come off of the bed pan. Care was provided and the resident was noted to have pain and altered skin integrity.

Progress notes on the same day, written by Physiotherapist Assistant #104 indicated that the resident reported that they were treated roughly. Interview with the staff, confirmed that they had written the progress note and stated that they had reported to their supervisor, the Physiotherapist.

PSW #103 who no longer worked in the home was unavailable for an interview. PSW #105 who was referred to in the progress note written by PSW #103 reported that they were aware of an allegation about PSW #103 but did not hear the allegation directly from the resident and could not confirm the allegation.

Interview with the Physiotherapist reported that they were aware of the allegation and that they had a discussion about the progress note with the Physiotherapist Assistant. The Physiotherapist reported that they had spoken to the Nurse Manager and/or the DOC about the allegation.

The DOC reported that the alleged staff to resident abuse incident related to complaint log #011644-18 was investigated including interview with PSW #103. The DOC stated that any notes would be considered part of the resident record; however, reported that any notes following the internal investigation had been destroyed. The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least ten years after the resident was discharged from the home [s. 233. (1)]

Issued on this 1st day of October, 2019

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

Original report signed by the inspector.