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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: February 5, 2025

Inspection Number: 2025-1130-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: The Norfolk Hospital Nursing Home

Long Term Care Home and City: The Norfolk Hospital Nursing Home, Simcoe

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 20, 21, 23, 24, 27, 28, and 30, 2025
The inspection occurred offsite on the following dates: January 30, 31, 2025 and February 3, 4, and 5, 2025

The following intake was inspected:

- Intake: #00132484 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Posting of information

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (1)
Posting of information
s. 85 (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements if any, established by the regulations.

An initial tour of The Norfolk Hospital Nursing Home was completed as a part of a Proactive Compliance Inspection (PCI), which noted the following required information was not posted in the home in a conspicuous and easily accessible location in a manner that complied with the Ontario Regulations 246/22 s. 85 (1):

(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 28 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;

(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained.

Sources: Observations in the home, and interview with Nurse Manager.

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that that the home was maintained at a minimum temperature of 22 degrees Celsius.

Air temperatures were reviewed and it has been noted that on few occasions the air temperature was below 22 degrees Celsius in some resident's rooms. Director of Facilities & Capital Projects and Environmental Services Lead stated that they were not aware that on few occasions the air temperature in the home was below 22 degrees Celsius in some resident's rooms.

Sources: Review of air temperature log, interview with Director of Facilities & Capital Projects and Environmental Services Lead

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms, in different parts of the home, one resident common area on every floor, and every designated cooling area of the home.

Review of air temperature records showed there was no documentation of measured air temperatures on several occasions. Director of Facilities & Capital Projects and Environmental Services Lead stated that they were not aware that the air temperature was not measured and documented in writing on several occasions.

Sources: Documented temperature records, and interview with Director of Facilities & Capital Projects and Environmental Services Lead

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) The licensee failed to ensure that the skin and wound program, as required under sections 53 of this Regulation, was evaluated and updated in 2024.

Sources: Interview with Director of Care (DOC) and review of the home's Skin and Wound Program policies and protocols.

B) The licensee failed to ensure that the pain program, as required under sections 53 of this Regulation, was evaluated and updated in 2024.

Sources: Interview with Director of Care (DOC) and review of the home's Pain Program policies and protocols.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee has failed to ensure that a written staffing plan for the home was

available.

During a Proactive Compliance Inspection (PCI), Administrator and Director of Care (DOC) of the home noted that they did not have a written staffing plan for the programs referred to in clauses (1) (a) and (b) of the Ontario Regulations 246/22.

Sources: Interview with Administrator and Director of Care.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team, that included the Administrator, met at least quarterly in 2024, to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The last Quarterly Review of the Medication Management system of the home was in 2024. The Administrator of the home was not in attendance at this meeting.

Sources: Interviews with Director of Care (DOC), review of Quarterly Pharmacy Report and Medication Management Audit December 2024.

WRITTEN NOTIFICATION: Annual evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 125 (1)

Annual evaluation

s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met in 2024 to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home was unable to provide an annual evaluation of the effectiveness of the medication management system in the home for 2024.

Sources: Interviews and emails with Director of Care (DOC), review of Quarterly Pharmacy Report and Medication Management Audit December 2024.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.

Drug destruction and disposal

s. 148 (2) The drug destruction and disposal policy must also provide for the following:

1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that non-narcotic drugs that were to be destroyed and disposed of, were stored safely and securely within the home.

The inspector observed that non-narcotic tablets were disposed of into an unlabeled white pail in the locked medication room with lid not snapped on. The medications were not denatured and labels on creams, ointments and eye drops were not obliterated.

There was risk related to the improper safe storage of non-narcotic medications that were to be disposed of and destroyed being accessible to registered staff in the home.

Sources: Observations of the medication room and bins, interviews with staff, review of the home's policy-Disposal and Destruction of Non-narcotic/controlled Medications and Insulin Index Section 9.10, Effective Date: March 1, 2018, Reviewed Date: January 7, 2021, Modified Date: April 11, 2022.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (1)

Continuous quality improvement initiative report

s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report on the Continuous Quality Improvement initiative for the home was prepared for each fiscal year no later than three months after the end of the fiscal year, and a copy of each report was published on the home's website.

Sources: Interview with Director of Care (DOC).

COMPLIANCE ORDER CO #001 Continuous quality improvement committee

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A. Establish a continuous quality improvement committee. Ensure the continuous quality improvement committee is composed of the following members:

    1. The home's Administrator.
    2. The home's Director of Nursing and Personal Care
    3. The home's Medical Director.
    4. Every designated lead of the home.

5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52 of the O. Reg. 246/22.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

B. Develop a process to ensure:

1. monitoring and reporting to the long-term care home licensee on quality issues, residents' quality of life, and the overall quality of care and services provided in the long-term care home, with reference to appropriate data.
2. considering, identifying and making recommendations to the long-term care home licensee regarding priority areas for quality improvement in the home. Ensure the recommendations are documented and kept in the home.

Grounds

The licensee has failed to ensure that a Quality Improvement Committee (QIC) was established in the home.
Director of Care (DOC) acknowledged that a QIC was not established in the home and did not exist at least since April 2024.

As a result of the home not having an established Quality Improvement Committee, there was risk to the residents as the home did not monitor and report to the licensee on quality issues, residents' quality of life, and other overall quality of care and services provided in the long-term care home.

Additionally, the home did not consider, identify, and make recommendations to the licensee regarding priority areas for quality improvement in the home. Furthermore, the home did not coordinate and support the implementation of the continuous quality improvement initiative, including but not limited to preparation of the report on the continuous quality improvement initiative.

Sources: Interview with Director of Care (DOC).

This order must be complied with by March 17, 2025

COMPLIANCE ORDER CO #002 Emergency plans

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (1)
Emergency plans
s. 268 (1) This section applies to the emergency plans required under subsection 90 (1) of the Act.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A. Develop and implement an emergency plan specific to the long-term care home.

B. Ensure the emergency plan specific to the long-term care plan includes:

1) Dealing with emergencies, including, without being limited to,

i. outbreaks of a communicable disease, outbreaks of a disease of public health significance, epidemics and pandemics,

ii. fires,

iii. community disasters,

iv. violent outbursts,

v. bomb threats,

vi. medical emergencies,

vii. chemical spills,

viii. situations involving a missing resident,

ix. loss of one or more essential services,

x. gas leaks,

xi. natural disasters and extreme weather events,

xii. boil water advisories, and

xiii. floods.

2. Evacuation plans for the home, including, at a minimum,

i. a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency,

ii. identification of a safe evacuation location for which the licensee has obtained agreement in advance that residents, staff, students, volunteers and others can be evacuated to,

iii. a transportation plan to move residents, staff, students, volunteers and others to the evacuation location, and

iv. a plan to transport critical medication, supplies and equipment during an evacuation to the evacuation location to ensure resident safety.

3. Resources, supplies, personal protective equipment and equipment vital for the emergency response being set aside and readily available at the home including, without being limited to, hand hygiene products and cleaning supplies, as well as a process to ensure that the required resources, supplies, personal protective equipment and equipment have not expired.

4. Identification of entities that may be involved in or that may provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the Connecting Care Act, 2019, partner facilities and resources that will be involved in responding to the emergency and the current contact information for each entity.

5. Identification of the roles and responsibilities of the entities referred to in paragraph 4 and a plan for consulting with such entities on their involvement.

6. A plan for food and fluid provision in an emergency.

7. A plan to ensure that in an emergency all residents have timely access to all drugs that have been prescribed for them.

C) Ensure that the emergency plans address the following components:

1. Plan activation, including identifying who or which entity declares there is an emergency at the home and who or which entity declares that the emergency is over at the home, as agreed upon by the entities the licensee consulted with under clause (3) (a).

2. Lines of authority.

3. A communications plan.

4. Specific staff roles and responsibilities.

D) The licensee shall ensure that the communications plan includes a process for the licensee to ensure frequent and ongoing communication to residents, substitute decision-makers, if any, staff, volunteers, students, caregivers, the Residents' Council and the Family Council, if any, on the emergency in the home including at the beginning of the emergency, when there is a significant status change throughout the course of the emergency, and when the emergency is over.

E) Ensure that a current recorded version of the emergency plans is available on the home's website, and physical copies of it are made available on request.

Grounds

The licensee has failed to ensure that an emergency plan specific to the long-term care home was developed and recorded in writing.

During a Proactive Compliance Inspection (PCI), it was noted that the home had an emergency plan for the hospital, but was unable to produce a written emergency plan specific to the long-term care home.

Not having an emergency plan specific to the long-term care home prevented the home from having clear directions to staff on procedures to minimize the impacts and risks from any potential emergency, and ability to restore normal operations as soon as possible in the event of an emergency. Failure to develop and implement an emergency plan specific to the long-term care home put the residents at risk.

Sources: Review of relevant documentation and interview with Administrator and Director of Care.

This order must be complied with by March 17, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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