Ontario

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

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

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

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 20, 22, Jul 13, Aug 16, 2012 | 2012_027192_0034 | Critical Incident |

**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**

DEBORA SAVILLE (192)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, Nurse Manager, Registered Nurse, Registered Practical Nurse,Personal Support Worker and residents related to H-000716-12.**

**During the course of the inspection, the inspector(s) reviewed medical records, and staffing schedules.**

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

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 subsections:**

**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. 2007, c. 8, s. 6 (7).**

**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;**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. Previously issued as a WN August 2011.

The licensee failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

The plan of care for resident 001 indicates that 1:1 staffing is to be provided during the day time. Interview and a review of the schedule indicate that 1:1 staffing has not been provided to resident 001 since a specified date in 2012. Record review indicates that the resident continues to exhibit responsive behaviours and resident 001 was observed demonstrating behaviours during the course of this inspection. There is no documentation indicating the assessment process to validate the discontinuation of interventions that had been effective. Staff interviewed were unable to identify an assessment process related to the behaviours of the resident and completed prior to changing the interventions.

2. The licensee failed to 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 the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

a) The plan of care for resident 001 indicates that there is to be monitoring of the resident every 15 minutes due to an identified risk. Interview and documentation review indicate that concerns related to the identified risk have resolved. The resident no longer requires monitoring every 15 minutes, however the plan of care has not been updated to reflect this change.

b) The Nurse Manager of the home indicated that a plan was currently in place to transition resident 001 into a different room. The plan of care does not include the process for transition or assessment to determine the safety of this resident residing in a different room.

*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 ensuring that care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. [r. 98]

a) In 2012 resident 001 abused resident 002.

b) Interview and record review confirm that the home did not immediately notify the Police of this incidence of abuse.

c) When asked if the incident had been reported to police the Director of Care indicated that it had not, but the home had notified a third party that the police would be contacted at their discretion, indicating the licensee suspected resident 001's actions may have constituted a criminal offense.

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions. [r. 54. (b) ]

a) Resident 001 has a history, since admission, of responsive behaviours. In 2012, resident 001 abused resident 002. Interventions were put in place due to the incident. These interventions have been gradually withdrawn yet resident 001 continues to exhibit behaviours.

b) In 2012 resident 001 was observed demonstrating responsive behavours towards another resident. There was no interaction between the two residents to provoke the incident.

c) Record review indicates that resident 001 has exhibited escalating behaviours since 1:1 monitoring has stopped and with recent changes in medication. Through a one month period in 2012 there are almost daily documented incidents of behaviour directed toward other residents.

*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 ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions, to be implemented voluntarily.*

**Issued on this 7th day of September, 2012**

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

Deborah Saville (192)