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
Aug 12, 16, 18, ~~Oct 14~~ (nt error) 2011	2011_064167_0015	Complaint

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Director of Care and the Nurse Manager.

During the course of the inspection, the inspector(s) conducted a review of the health file for an identified resident including consultant's reports, reviewed correspondence between the licensee and the identified resident, reviewed the home's record of staff training related to specific treatments for the identified resident and the home's Pain Management Policy.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Pain

Personal Support Services

Reporting and Complaints

Training and Orientation

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Findings of Non-Compliance were found during this inspection.

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. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Written complaints submitted to the licensee by an identified resident, related to care issues were not forwarded to the Director as required.

The identified resident submitted correspondence to the Director of Care related to care issues.
These written complaints were never forwarded to the Director.

WN #2: 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).

Findings/Faits saillants :

1. The identified resident, did not receive the care set out in their plan of care as specified in the plan.

The identified resident was to receive a treatment three times per day as per the physician's order.
The Treatment Administration Record for the identified resident indicates that the treatment was not offered to them as per the physician's order 22 times over a period of one month.
The Treatment Administration Record for the identified resident the following month indicates that the treatment was not offered to them as per the physician's order 25 times during that month.

Issued on this 29th day of November, 2011

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

Marilyn Love