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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2013	2013_188168_0026	H-000505-13	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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 17 and 18, 2013

This inspection was observed, in part, by inspector Valerie Goldrup.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the charge nurse, registered nursing staff, personal support workers (PSW) and residents.

During the course of the inspection, the inspector(s) observed the provision of care on the evening and night shift and reviewed the clinical records of specified residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 care set out in the plan of care was not provided to the residents as specified in the plan.

A. Resident #002 was observed on October 17, 2013, beginning at 1432 hours until they went to bed at 1832 hours. The plan of care identified that the resident was to be toileted before and after meals, which was confirmed by PSW staff. The resident was not toileted before the evening meal, only after eating and before retiring for the evening.
B. The plan of care for resident #001 identified the need for toileting before and after meals and at bedtime. On October 17, 2013, the resident was monitored from 1432 hours until they retired for the evening at 2028 hours. The resident was toileted when going to bed at 2028 hours, however not before or after the evening meal.
C. The plan of care for resident #004 identified the need to be turned and repositioned with skin care every two hours and toileted before and after meals. The resident was monitored on October 17, 2013, beginning at 1432 hours until they retired for the evening at 2000 hours.
i) The resident was up in the wheelchair during the observation period and was not repositioned by staff until 1709 hours, greater than a two hour period of time.
ii) The resident was not toileted before or after the evening meal as indicated in the plan of care, only prior to going to bed, which was confirmed during an interview with the PSW staff. [s. 6. (7)]

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 care set out in the plan of care is provided to the residents as specified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care was not based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A. Resident #003 was observed to be up and dressed at 0547 hours on October 18, 2013. PSW staff interviewed identified that the resident was routinely provided morning care and transferred to the wheelchair prior to 0600 hours, due to a known identified behaviour. The plan of care did not identify the need for early rising as an intervention to manage the behaviour. Interview with the charge nurse confirmed that the home did not have a formalized assessment for resident's sleep and rest patterns and preferences.
B. Resident #007 was observed to be up and dressed at 0538 hours on October 18, 2013. PSW staff interviewed identified that the resident was routinely provided morning care and transferred to the wheelchair prior to 0600 hours, due to a known identified behaviour. The plan of care did not identify the need for early rising. Interview with the charge nurse confirmed the behaviour and the established routine for morning care. [s. 26. (3) 21.]

WN #3: 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. (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 did not ensure that a resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The supper meal service was monitored on October 17, 2013. Resident #005 was noted to have a full hot entree out of reach on their table at 1748 hours. It was observed that staff did not assist the resident to eat until 1801 hours. Staff confirmed the resident required one to one assistance to eat and that the meal was typically served to the resident before staff had time to provide the assistance required. [s. 73. (2) (b)]

Issued on this 18th day of October, 2013

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

L Vink