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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 4, 2017	2017_556168_0036	026017-17	Resident Quality Inspection

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), DIANNE BARSEVICH (581), JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 20, 21, 22, 24 and 27, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered dietitian (RD), charge nurse, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed relevant policies and procedures, meeting minutes and clinical health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **8 VPC(s)**
- **1 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	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. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continued contact with residents, training in the areas set out, at times or intervals as provided for in the regulations, abuse recognition and prevention, mental health issues, including caring for persons with dementia, behaviour management, how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations, palliative care, and any other areas provided for in the regulations.
Ontario Regulation 79/10 section 221(2), for the purposes of paragraph 6 of subsection 76 (7) of the Act, identified that the following were areas in which training was to be provided to all staff who provided direct care to residents: skin and wound care, continence care and bowel management, for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply PASDs (personal assistance services devices) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

According to the Regulations under section 221, subsection 2 (1), the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

A request was made of the DOC to provide records of direct care staff for training,

completed in 2016, in the areas of: skin and wound, minimizing of restraints and PASDs, and continence care and bowel management.

The DOC identified awareness that mandatory training had not been completed by all direct care staff in 2016.
It was identified that the home encouraged/directed the staff to complete the training; however, did not pay for the training to be completed, if done outside of hours worked at the home.
It was noted that the majority of training was offered online, via SURGE learning, guest speakers, for example the pharmacy service provider, and additionally some policies and procedures were discussed informally at staff meetings.
A review of the staff meeting minutes provided for 2016 included, at times high level highlights of specific procedures; however, were not reflective that training was provided, as confirmed by the DOC.
A review of the SURGE Course Completion records, for the time period of January 1, 2016, until December 31, 2016, identified the following:
a. Training on skin care and pressure ulcers: that 31.1 percent (%) of staff were provided the training as required; however, 68.9% of the staff were not trained.
b. Training on minimizing of restraints and PASDs: that 40% of staff were provided the training as required; however, 60% of the staff were not trained.
c. Training on continence care and bowel management: that 31.1% of the staff were provided the training as required; however, 68.9% of the staff were not trained. [s. 76. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 the rights of residents were fully respected and promoted, related to his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 being kept confidential in accordance with that Act.

On November 20, 2017, the "staff only" room, located on the ground floor, beside the staff locker room, was unlocked and unattended.
The room contained six filing cabinets each which were not secured.
Three of these cabinets contained health care records.
Staff secured each cabinet, which included the health care records, shortly after the area was observed by the Inspector.
Interview with the DOC confirmed that the room was not locked and that the cabinets contained clinical health records, with personal health information, which belonged to long-term care residents.
The DOC verified that the personal health information, when observed by the Inspector, was not secured, was accessible and plans to secure the area on a permanent basis. [s. 3. (1) 11. iv.]

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 rights of residents is fully respected and promoted to 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, to be implemented voluntarily.

WN #3: 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a. Resident #015's documented plan of care, under the eating section, identified, that they were not to have a specific item at at the place setting due to risk of ingestion; however, the resident was observed in the dining room at lunch on a specified date in November 2017, with the item at their place setting.
The plan of care was not provided to the resident as specified in the plan.
b. The plan of care for resident #014, included an intervention to be positioned in a specific way when in bed which was consistent with a sign posted above the bed.
The resident was observed, in bed, on a specific day in November 2017, at 1345 hours, not in the identified position.
Interview with PSW # 113 indicated that they, along with PSW #111, placed the resident to bed following the noon meal on the identified day.
PSW #113 verified that they were aware of the specific intervention; however, failed to do so on the identified date and noted that this was an oversight. [s. 6. (7)]

2. The licensee failed to ensure the resident was 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 changed or care set out in the plan was no longer necessary.

Review of the plan of care identified that resident #021 had aids and staff were to maintain them.
Observation and interview with the resident revealed they did not use the aids.
Interview with RPN #114 stated the resident did use the aids but not since July 2017 and confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act of this regulation requireed the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the plan, policy, protocol, procedure, strategy or system was complied with

A. Ontario Regulation 79/10, section 68 required "a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter".

The home's policy, Weight and Height Assessment, II-c-120 (1), last revised January 1, 2017, indicated that either the Nurse Manager, RN or RPN would measure each resident's height within the first week of admission and at the time of their annual Resident Assessment Instrument Minimum Data Set (RAI-MDS) review thereafter.
During the inspection it was identified that not all residents had their heights taken and recorded annually.
Records identified that 15 of 40 residents reviewed, who resided in the home for greater than 13 months, did not have their height completed on an annual basis.
Interview with the DOC on November 24, 2017, confirmed the expectation that resident heights were taken on admission and annually thereafter; however, there was likely an oversight for those residents who were identified to not have a height recorded since 2015 or 2016.
The DOC also indicated that PSWs were responsible to complete the height measurements, not the Nurse Manager or registered staff as per the home's policy.

B. Ontario Regulation 79/10 section 48(1)3 required the home to have a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The home's policy, Continence Care and Bowel Management Program, II-c-36, last reviewed January 30, 2017, directed the registered nursing staff to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument, titled Bladder and Bowel Continence Assessment, on admission, quarterly, and after any change in condition that may affect bladder or bowel continence.
i. Resident #010 had a Bladder and Bowel Continence Assessment form completed on admission in 2016.
The resident's Minimum Data Set (MDS) Assessment dated August 2017, identified that their urinary continence level had deteriorated.
A review of the resident's clinical health record did not include any further Bladder and Bowel Continence Assessments.
ii. Resident #021 had a Bladder and Bowel Continence Assessment form completed on admission in 2016.
The resident's MDS assessment dated June 2017, identified that their urinary continence level had improved, and the assessment from September 2017, identified that they had deteriorated.
A review of the resident's clinical health record did not include any further continence assessments.
iii. Resident #018 was admitted to the home in 2017.
A review of the clinical record included an admission Bladder and Bowel Continence Assessment; however, no additional Bladder and Bowel Continence Assessments were included in the clinical record.
In an interview, with the DOC, on November 27, 2017, they acknowledged and confirmed that the Bladder and Bowel Continence Assessments were completed annually and not quarterly as per the home's policy.

C. Ontario Regulation 79/10 section 48(1)2 required the home to have a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home's policy, Skin & Wound Care Program, II-c-140, last reviewed January 30, 2017, directed registered staff to complete a pain assessment on a resident upon discovery of a pressure ulcer.

a. Progress notes included that resident #011 had a pressure ulcer identified in May 2017.
The resident did not have a pain assessment completed until June 2017.
The DOC verified, following a review of the clinical record, that the resident did not have a pain assessment completed, as required, when the area was first identified first identified.
b. Resident #015 was identified with two new areas of altered skin integrity, pressure ulcers, in September 2017.
A review of the clinical record included pain assessments completed in July and October 2017.
The October 2017, pain assessment was completed three weeks after the second area of altered skin integrity was identified.
Interview with the DOC verified that pain assessments were not completed, as required, according to the home's Skin and Wound Care Program, following a review of the clinical record. [s. 8. (1) (b)]

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 where the Act of this regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31.

a. On a specified date in November 2017, resident #042 was observed in their chair, with a device secured in place.
Review of the plan of care did not include an assessment for the device.
When the resident was observed four days later, there was no device applied.
Interview with PSW #108, stated the resident did not require the device and when applied the resident was not able to release it independently.
Interview with RPN #109 confirmed that the resident was not assessed for the device and that it should not have of been applied, when observed by the Inspector.
b. On a specified date in November 2017, resident #044 was observed in their chair, with a device secured in place.
Review of the plan of care did not include an assessment of the device.
The resident was observed four days later, without a device applied.
Interview with RPN #104 confirmed that the resident was not assessed for the device and that it was previously applied by mistake. [s. 30. (1) 3.]

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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD (personal assistance services device) described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

According to Ont Reg 79/10 section 33(4)1 the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living may only be included in a resident's plan of care if alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or were not effective to assist the resident with the routine activity of living.

On November 20, and 21, 2017, resident #015 was identified to be in a chair, in a position with a device in place.
Staff interviewed confirmed the use of the devices as PASDs.
A review of the plan of care noted the use of the devices as a PASDs.
A review of the clinical record included approval for the devices and consent; however, did not include an assessment of the device, specifically the alternatives to the PASDs that were tried and /or considered, as verified by the DOC following a review of the record. [s. 33. (3)]

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 PASD (personal assistance services device) described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, they were assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

In 2017, resident #020 fell and sustained an injury.
Review of the plan of care identified that the assessment completed post fall was recorded in the progress notes and on the "Resident Incident Report".
The Resident Incident Report identified that it could be utilized for a number of incidents that included: injury, assault, fire, communicable disease, medication error and/or elopement.
Interview with RN #101 stated that when a resident had fallen, the registered staff would complete the post fall assessment on the Resident Incident Report and complete a falls risk assessment in Point Click Care (PCC).
Interview with DOC confirmed that the assessments completed post fall was not completed using a clinically appropriate assessment instrument that was specifically designed for falls.
The DOC confirmed that all assessments completed post fall in the home were currently completed on the Resident Incident Report. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a. According to the progress notes and electronic treatment administration records (eTAR) resident #015 was identified to have areas of altered skin integrity on two dates

in September 2017.
A general notation of the areas were recorded in the progress notes.
The clinical record did not include a skin assessment, of the resident, on the identified dates, using a clinically appropriate assessment instrument that was specially designed for skin and wound assessment as confirmed by the DOC, following a review of the documentation.
b. A review of the clinical record identified that resident #011 had one newly identified area of altered skin integrity.
The progress notes included an area of altered skin integrity, identified previously in May 2017.
The area did not have an initial assessment completed.
The DOC verified that the resident did not have an assessment of the areas completed, as required, when first identified using a clinically appropriate assessment instrument.
The DOC indicated that they had just obtained a skin and wound assessment, which would be utilized with new areas of altered skin integrity, once it was finalized, as they did not previously have clinically appropriate assessment instrument in use. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that any resident, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A review of the clinical record identified that resident #011 had a newly identified area of altered skin integrity, identified in May 2017.
There was no documentation in the clinical record of a referral to the RD, nor a record of any assessments completed by the RD as a result of the changes in skin integrity until the following month, when the RD commented on the area during their annual evaluation.

Interview with the DOC on November 27, 2017, identified that the RD was in the home once per week.
The DOC acknowledged that an RD referral form could not be located in the record and an assessment not completed until one month after the area was identified.
In an interview with the RD, on November 27, 2017, they confirmed that they had not received a referral and did not assess the resident until they completed the annual assessment one month later. [s. 50. (2) (b) (iii)]

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 resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and that the resident is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided a copy of the medication incident and adverse drug reaction reports for the past six months.
A review of the reports and resident specific documentation did not consistently include an assessment of the residents, nor that all of the required parties were informed of the incidents.
a. According to a Medication Incident Report, resident #013, was involved in a medication incident in July 2017.
A review of the progress notes, around the time of the incident, and the incident report, did not include an assessment of the resident to maintain their health, nor that the physician, the resident or the resident's Substitute Decision Maker (SDM) were notified of the incident.
b. According to a Medication Incident Report, resident #021, was involved in a medication incident in October 2017.
A review of the progress notes, around the time of the incident, and the incident report, did not include an assessment of the resident to maintain their health nor that the resident or the resident's SDM were notified of the incident.
The DOC, following a review of the incident reports and progress notes, verified that the medication incidents which involved resident #013 and #021, were not reported to all required parties and that there was no documentation to support that the residents were assessed related to the incidents. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions had corrective action taken as necessary and that a written record was kept of everything as required.

On request the home provided reports of all medication incidents and adverse drug reactions for the past six months.
According to a Medication Incident Report, resident #013, was involved in a medication

incident in July 2017.
A review of the incident report identified that a medication was added to the electronic Medication Administration Record (eMAR), after it had been discontinued by the physician, as the medication was still available in the medication cart.
Staff administered the medication according to the eMAR, when requested by the resident, unaware that there was not a current physician's order for the medication.
A review of the Medication Incident Report and report for the Canada Institute for Safe Medication Practices identified that the staff member was spoken to regarding and was aware of the incident; however, there were no records to support the specific corrective action taken, specifically if the discussion was related to the adding the medication onto the eMAR, the administration of the medication or failure to remove the medication from the medication cart when it was discontinued.
A review of the documents by the DOC verified that there was not clear documentation of the corrective action taken related to the incident. [s. 135. (2)]

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 medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to the areas by residents and that the doors were be kept closed and locked when they were not supervised by staff.

a. On November 20, 2017, it was identified that the ground floor, staff locker room door, had the ability to be locked with a key; however, was unlocked and unattended.
The room contained lockers for staff belongings and was not equipped with a communication and response system.
Interview with the DOC verified that the room was a non-residential area, that was left unlocked and unattended for staff use.
The DOC identified that the door would be locked and a key provided for staff use immediately.
The area was noted to be secured on November 21, 2017.
b. On November 20, 2017, the door to the "staff only" room, located on the ground floor, beside the staff locker room, was a push style door and did not have the ability to be locked.
This room contained six filing cabinets, which were not secured, and three were identified to contain health records.
An interior door in the "staff only" room lead to a staff bathroom with two stalls.
The room containing the filing cabinets nor the bathrooms were equipped with a communication and response system.
Interview with the DOC confirmed that the door did not have the ability to be locked and that the rooms were non-residential areas which were left unlocked and unattended.
The DOC expressed plans to secure the "staff only" room as soon as possible.
Maintenance staff were observed to install a key locking style door knob on the door on November 23, 2017. [s. 9. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The plan of care for resident #018 identified that they were to have specific care after each meal.
The resident reported that the staff did not assist or provide the specific care daily.
On observation the resident's care supplies were not utilized following the noon meal on November 24, 2017.
Interview with PSW #113 identified that the resident consistently refused the care.
Interview with PSW #118 and #107 identified that the resident would allow the provision of the specific care dependent on specific situations.
A review of the Point of Care (POC) documentation records, for the past 30 days, identified that the resident consistently received the care twice a day only, with only one day recorded as care provided three times in a 24 hour period; however, there was no documentation of the refusal of the care.
Interview with the DOC verified the expectation to document the refusal of care in POC as well as the intervention of the specific care three times as day as per the plan of care. [s. 30. (2)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), DIANNE BARSEVICH (581), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2017_556168_0036
Log No. / No de registre :	026017-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 4, 2017
Licensee / Titulaire de permis :	NORFOLK HOSPITAL NURSING HOME (THE) 365 WEST STREET, SIMCOE, ON, N3Y-1T7
LTC Home / Foyer de SLD :	THE NORFOLK HOSPITAL NURSING HOME 365 WEST STREET, SIMCOE, ON, N3Y-1T7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Issan

To NORFOLK HOSPITAL NURSING HOME (THE), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that all direct care staff are provided training on:

i. skin and wound care,
ii. continence care and bowel management;
iii. the application, use and potential dangers of physical devices to restrain residents and PASDs (personal assistance services devices).

There shall be a record of the training provided to each employee.

This record shall include the date that the training was completed, topics covered and who/how the training was completed.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect of the risk of harm toward the residents, the scope of a widespread, and the Licensee's history of unrelated non-compliance related to staff training.

The licensee failed to ensure that all staff who provided direct care to residents

received, as a condition of continued contact with residents, training in the areas set out, at times or intervals as provided for in the regulations, abuse recognition and prevention, mental health issues, including caring for persons with dementia, behaviour management, how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations, palliative care, and any other areas provided for in the regulations.
Ontario Regulation 79/10 section 221(2), for the purposes of paragraph 6 of subsection 76 (7) of the Act, identified that the following were areas in which training was to be provided to all staff who provided direct care to residents: skin and wound care, continence care and bowel management, for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply PASDs (personal assistance services devices) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

According to the Regulations under section 221, subsection 2 (1), the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

A request was made of the DOC to provide records of direct care staff for training, completed in 2016, in the areas of: skin and wound, minimizing of restraints and PASDs, and continence care and bowel management.

The DOC identified awareness that mandatory training had not been completed by all direct care staff in 2016.
It was identified that the home encouraged/directed the staff to complete the training; however, did not pay for the training to be completed, if done outside of hours worked at the home.
It was noted that the majority of training was offered online, via SURGE learning, guest speakers, for example the pharmacy service provider, and additionally some policies and procedures were discussed informally at staff meetings.
A review of the staff meeting minutes provided for 2016 included, at times high level highlights of specific procedures; however, were not reflective that training was provided, as confirmed by the DOC.
A review of the SURGE Course Completion records, for the time period of January 1, 2016, until December 31, 2016, identified the following:
a. Training on skin care and pressure ulcers: that 31.1 percent (%) of staff were

provided the training as required; however, 68.9% of the staff were not trained.
b. Training on minimizing of restraints and PASDs: that 40% of staff were provided the training as required; however, 60% of the staff were not trained.
c. Training on continence care and bowel management: that 31.1% of the staff were provided the training as required; however, 68.9% of the staff were not trained. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : LISA VINK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office