Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2020	2020_782736_0004	020244-19, 022379-19, 001193-20	Critical Incident System

Licensee/Titulaire de permis

The Norfolk Hospital Nursing Home
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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 10-13, 2020.

The following intakes were completed in this Critical Incident System Inspection:
-three logs related to resident falls with significant changes in health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care(ADOC), Registered Nurse(s) (RNs), Registered Practical Nurse(s)(RPNs), Personal Support Worker(s)(PSWs), and residents.

During the course of the inspection, the Inspector reviewed relevant resident health care records, observed the provisions of care, and reviewed relevant licensee policies.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **0 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	Légende 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 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 has failed to ensure that when a resident had fallen, the resident had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) report was submitted to the Director, related to resident #001 who had sustained a fall, and an injury that resulted in a significant change in their health status.

Inspector #736 reviewed resident #001's progress notes, which indicated that on the specified date, the resident was found on the floor by Registered Nurse (RN) #102.

The Inspector reviewed the assessments for resident #001, and located a "NHNH Post Fall Assessment", opened on the specified date that the resident had been found on the floor. The Inspector reviewed the assessment, and noted that all fields within the assessment were blank.

In separate interviews with Registered Practical Nurse (RPN) #104 and RN #103, they both indicated that after a resident had sustained a fall, the registered staff were to complete the Post Fall assessment on Point Click Care (PCC). Separately, both RPN #104 and RN #103 reviewed the Post Fall assessment that was opened for resident #001 on the specified date; the RPN confirmed that the assessment had not been completed, and should have been.

A review of the licensee's policy titled "Falls Prevention and Management Program", # II-c-67, last reviewed September 30, 2016, directed registered nursing staff to complete a Post Fall screen for residents after a resident had sustained a fall.

In an interview with the Director of Care (DOC), they indicated to the Inspector that after a resident had sustained a fall, registered staff were to complete a Post Fall assessment on PCC. Together, the DOC and Inspector reviewed the Post Fall assessment that was opened for resident #001 on the specified date. The DOC indicated that that the assessment was blank. The DOC further indicated that due to the assessment being blank, resident #001 had not been assessed after their fall on the specified date, using the clinically appropriate assessment instrument. [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 after a resident has fallen, the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A CI report was submitted to the Director related to resident #001, who had sustained a fall that resulted in an injury with a significant change in health status.

The Inspector noticed specific direction to staff, that indicated what level of assistance the resident required for transferring.

The Inspector reviewed resident #001's care plan, that under the heading "Transfers", which indicated that the resident was to be provided with a specific level of assistance the resident required with transferring, and the type of transfer that was to be utilized.

In separate interviews with PSW #105 and RPN #104, they both indicated that staff would review the resident's care plan to determine the resident's transfer status. During

the interview with PSW #105, they indicated that the resident required a specific level of assistance to transfer. RPN #104 indicated to the Inspector that resident #001 required a different level of assistance to transfer, but was unable to locate the specific directions in the resident's care plan.

In an interview with RN #103, they indicated to the Inspector that staff would utilize the resident's care plan to determine a resident's transfer status. The RN reviewed resident #001's care plan that indicated that the resident required a specific level of assistance for transfers. The Inspector then indicated that direction elsewhere in the resident's plan of care indicated that the resident required a different level of assistance for transfers. The RN indicated to the Inspector that the plan of care should have been consistent; and, as it was not, the resident's plan of care had not provided clear direction to staff who were providing care to resident #001.

In an interview with the DOC, they indicated to the Inspector that staff would refer to the resident's care plan, as well as other specified areas, to determine a resident's individual transfer status. Together, the DOC and Inspector reviewed resident#001's care plan, which indicated that the resident required a specific level of assistance for transfers. The Inspector indicated to the DOC that the plan of care located elsewhere indicated that the resident required a different level of assistance for transfers. The DOC indicated to the Inspector that the resident's plan of care had not provided clear direction to staff. [s. 6. (1) (c)]

2. A CI report was submitted to the Director related to resident #002, who had sustained a fall that resulted in a significant change in health status.

Inspector #736 observed direction to staff related to resident #002 that showed a specific transfer status; however, crossed out, with a hand written note that provided different directions to staff.

The Inspector reviewed resident #002's care plan, and noted that under the heading "Transfers", it directed staff that the resident was a certain transfer status, and that, at a later time, staff would provide further direction on how to transfer the resident.

In an interview with PSW #106, they indicated that staff would refer to a resident's care plan to determine the individual transfer status of each resident. The PSW confirmed that the plan of care had a specific level of transfer indicated, however, the plan of care also indicated the resident was to be transferred by a different method.

In an interview with RN #103, they indicated to the Inspector that staff would refer to a resident's care plan and other specified areas, to determine the resident's transfer status. The RN indicated to the Inspector that based on what was written in the resident's care plan, and what was in other specified locations, the plan of care had not provided clear direction to staff who were providing care to resident #002, related to transfers.

In an interview with the DOC, they indicated to the Inspector that staff would refer to the resident's care plan and other specified areas, to determine how to transfer a specific resident. Together, the DOC and Inspector reviewed resident#002's care plan, and the DOC indicated that the resident's care plan indicated that the resident required two different levels of assistance for transfers. The DOC indicated that the plan of care had not provided clear direction to staff related to resident #002's transfer status, and should have. [s. 6. (1) (c)]

WN #3: 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, that the strategy was complied with.

In accordance with Ontario Regulation 79/10 s. 49 (1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents. Specifically, staff did not

comply with the licensee's Falls Prevention and Management Program (II-c-67), which was part of the licensee's Falls Prevention program.

A CI report was submitted to the Director related to the fall of resident #003, who sustained a fall and sustained an injury that resulted in a significant change in health status.

Inspector #736 reviewed resident #003's progress notes, which indicated that the resident had sustained a fall on a specific date. The progress notes further indicated that the resident sustained an identified injury.

The licensee's policy titled "Fall Prevention and Management Program", # II-c-67, last reviewed September 30, 2016, directed registered staff to complete a Fall Risk Assessment after a resident had sustained a fall.

The Inspector further reviewed resident #003's electronic health record and noted a Fall Risk assessment dated in the fall of 2019. The Inspector was unable to locate any further Fall Risk assessments for the resident.

In separate interviews with RPN #104 and RN #103, they both indicated that after a resident had sustained a fall, the registered staff were to complete a Fall Risk assessment. Both the RPN and RN reviewed resident #003's electronic health record with the Inspector, and both noted that the last Fall Risk assessment had been completed in fall of 2019. Both the RPN and RN separately indicated to the Inspector that a few Fall Risk assessments should have been completed after resident #003 sustained a fall on the specific date.

In an interview with the DOC, they indicated to the Inspector that a resident was assessed for their falls risk quarterly, and after a resident had sustained a fall. The DOC reviewed the assessments for resident #003, and noted that the resident last had their fall risk level assessed in fall of 2019. The DOC indicated to the Inspector that resident #003 should have had their fall risk level re-assessed after they had sustained a fall on the specific date. The DOC further indicated that the home's falls policy had not been complied with, as the fall risk assessments had not been completed. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report included action taking in response to the incident, including the outcome or current status of the individual involved.

a) A CI report was submitted to the Director related to resident #001 having sustained a fall that resulted in an injury with a significant change in health status.

The CI report was submitted on a specified date, and had not included, at that time, the current status or outcome of the resident.

An amendment was requested to be returned, to include a description of the injury that the resident had sustained.

The Inspector reviewed the Long Term Care.net portal at the beginning of the inspection and was unable to locate an amended CI report that included the requested information.

In an interview with the DOC, they indicated to the Inspector that it was their responsibly to amend CI reports as needed, and they recalled receiving a request to amend the CI report for resident #001 after they had sustained a fall. The DOC indicated that they thought that they had amended the CI report; however, upon further review, they had saved the amendment in “draft” form. The DOC indicated that they should have submitted the amended CI report within the 10 days required.

b) A CI report was submitted to the Director related to resident #002 who had fallen and sustained an injury that resulted in a significant change in health status for the resident.

The CI report was submitted to the Director on a specified date, and had not included the current status or outcome of the resident.

An amendment was requested seven days later; however, at the start of the inspection, the Inspector was unable to locate an amendment on the Long Term Care.net portal.

In an interview with the DOC, they indicated to the Inspector that it was their responsibly to amend CI reports as needed, and they recalled receiving a request to amend the CI report for resident #001 after they had sustained a fall. The DOC indicated that they thought that they had amended the CI report; however, upon further review, they had saved the amendment in “draft” form. The DOC indicated that they should have submitted the amended CI report within the 10 days required. [s. 107. (4) 3.]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.