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
Nov 3, 2021	2021_857129_0007	008443-21	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

PHYLLIS HILTZ-BONTJE (129)

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): October 26, 27, 28 and 29, 2021.

The following Critical Incident System intake was inspected:
008443-21-related to a fall with injury

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Worker (PSW), Registered Nurse (RN) and the Assistant Director of Care (ADOC).

During this inspection the Inspector made observations of care provided to residents, observed resident rooms, reviewed resident clinical records and reviewed the Licensee's Fall Prevention and Management Program policies and completed a tour of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 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 :

The licensee failed to ensure that the plans of care for two residents provided clear direction to staff related to the assistance required during transfers.

a) A resident experienced a fall on an identified date in 2021, which resulted in the resident receiving injuries. The resident's current plan of care indicated the resident required one to two staff extensive assistance using a specific device and an identified maneuver for all transfers.

Personal Support Worker #102 acknowledged the care plan and Kardex did not indicate under which circumstances staff would assist the resident using one or two staff and the plan of care did not provide clear directions, especially to staff who may not be familiar with the resident.

During a discussion with the ADOC and RN #101, the plan of care for the resident was reviewed and both staff acknowledged that the plan of care did not provide clear directions to staff.

Failure of staff to ensure the written plan of care provided clear directions related to the number of staff required to transfer the resident, increased the risk that the resident may not be transferred safely by staff who were not familiar with the resident.

Sources: the resident's care plan and Kardex as well as interviews with PSW #102, RN #101 and the ADOC.

b) A second resident's plan of care indicated the resident required one to two staff extensive assistance for all transfers.

Personal Support Worker #102 acknowledged the care plan and Kardex did not identify under which circumstances staff would assist the resident using one or two staff and the plan of care did not provide clear directions, especially to staff who may not be familiar with the resident.

During a discussion with the ADOC and RN #101, the plan of care for the resident was reviewed and when it was identified that the plan of care directed the resident required one to two staff to provide extensive assistance for all transfers, but did not identify under what circumstances the resident would require one or two persons assistance, they

acknowledged that the plan of care did not provide clear directions to staff providing care to the resident.

Failure of staff to ensure the written plan of care provided clear directions related to the number of staff required to assist the resident with transfers, increased the risk that the resident may not be transferred safely by staff.

Sources: the resident's care plan and Kardex as well as interviews with PSW #102, RN #101 and the ADOC. [s. 6. (1) (c)]

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 and ensuring resident's plans of care provide clear directions to staff providing care, to be implemented voluntarily.

WN #2: 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 :

The licensee failed to ensure that staff complied with the Falls Prevention and Management Program policy when a resident fell.

O. Reg. 79/10, s. 30(1) requires there to be a written description of the organized interdisciplinary programs required under section 48 of the Regulation that includes relevant policies, procedures, and protocols.

O. Reg. 79/10 s. 48(1) 1 requires every licensee to ensure an interdisciplinary falls prevention and management program is developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management Program", dated January 30, 2011.

The Falls Prevention and Management Program policy required registered staff to "complete the on-line MOHLTC Critical Incident Report if a resident's fall resulted in the resident being transferred to hospital or admitted to hospital".

On an identified date, a resident experienced a fall and the resident was transferred to hospital for assessment and treatment of their injuries on the same day.

A CIS report submitted to the Director eight days later and the ADOC confirmed that staff had not complied with the licensee’s policy when they did not complete the” on-line MOHLTC Critical Incident Report” when the resident was transferred to hospital.

Sources: Falls Prevention and Management Program policy, the resident's clinical notes, CIS report and interview with the ADOC.

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 and ensuring staff comply with the directions in the Licensee's policies, to be implemented voluntarily.

WN #3: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that an interdisciplinary falls risk assessment was completed for a resident.

On two identified dates in 2021, the electronic clinical record indicated registered staff collected data and documented that data on a form identified as "Falls Risk Assessment", which then resulted in electronically generated falls risk scores.

During a discussion with the ADOC and RN #101, they confirmed that registered staff complete the falls risk assessment document and no other disciplines participate in an assessment of a resident's risk for falling.

Failure of staff to ensure other disciplines participated in the falls risk assessments for the resident, increased the risk that factors which may increase the resident's risk for falling may not be considered in the development of the plan to minimize the chance the resident may fall.

Sources: the resident's falls risk assessments and interviews with ADOC and RN #101.

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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee failed to ensure the Director was notified within three business days when a resident received injuries after experiencing a fall.

A Critical Incident System (CIS) report submitted to the Director indicated the resident experienced a fall eight days earlier, for which they were transferred to hospital and which resulted in a significant change in their health status.

Clinical notes made by registered staff indicated the resident fell which resulted in the resident being transferred to hospital on the same day. The following day a clinical note indicated staff contacted the hospital and were made aware that resident was awaiting transfer to another hospital for treatment of their injuries. On the same day, staff received a telephone message from the resident’s family member who informed the home that the resident would have surgery to treat their injury.

The Assistant Director of Care (ADOC) confirmed the Director had not been notified no later than three business days following an incident that required the resident to be transferred to hospital and which resulted in a significant change in their health status.

Sources: CIS report, the resident's clinical notes and an interview with ADOC.

Issued on this 3rd day of November, 2021

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

Original report signed by the inspector.