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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 25, 2015	2014_336580_0025	S-000534-14	Critical Incident System

Licensee/Titulaire de permis

675412 ONTARIO INC
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

NORTHVIEW NURSING HOME
77 RIVER ROAD P.O. BOX 1139 ENGLEHART ON P0J 1H0

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

VALA MONESTIMEBELTER (580)

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): December 29, 30 and 31, 2014.

This inspection is in regard to Log S-000534-14.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSWs), a Dietary Aide (DA), a Housekeeping Aide (HA), a Cook, Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Recreation Restorative Aide, the Associate Director of Care (ADOC) and the Administrator/Director of Care (DOC). The inspector also conducted a daily walk-through of the home, made direct observations of the delivery of care and services to the residents, observed staff to resident interaction, reviewed resident health care records and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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	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 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 the policy is complied with.

Inspector #580 reviewed the home's Critical Incident (CI) Report submitted to the Ministry of Health and Long Term Care (MOHLTC). The home indicated on the CI Report the date and time the incident of abuse occurred. The Administrator/DOC and ADOC confirmed to the Inspector that the home did not notify the MOHLTC about the abuse of resident #002 until two days later. The inspector reviewed the home's Abuse-Prevention, Reporting and Elimination of Abuse and Neglect policy CA-05-37 dated June 2010 which indicates that the "Administrator and/or designate must notify MOHLTC by phone immediately that an alleged, suspected or witnessed abuse or neglect has taken place or is likely to have taken place." [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that residents are protected from abuse by anyone.

According to Critical Incident (CI) Report, staff #301 was abusive to resident #002. Resident #002 confirmed to the inspector that the staff member was abusive to the resident. The administrator confirmed to Inspector #580 that the home investigated the incident and determined that staff to resident abuse had occurred and terminated the employee. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). O. Reg. 79/10, s. 47 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program.

Inspector #580 reviewed the personnel file of staff #301 which indicated that they had not completed a personal support worker program. The Administrator/DOC confirmed that the staff member had not completed a personal support worker program. [s. 47. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Inspector #580 toured the home and was not able to find the Whistle-blowing Protection information posted in the home. The ADOC confirmed to the inspector that they have not seen the Whistle-blowing Protection information posted anywhere in the home. Staff #203 and staff #204 confirmed to the inspector that they do not know where the information for Whistle-blowing protection is posted. [s. 79. (1)]

Issued on this 25th day of February, 2015

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

Original report signed by the inspector.