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, 2015	2014_336580_0026	S-000334-14, S-000397-14, S-000594-14	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): December 29, 30 and 31, 2014.

This inspection is in regard to Logs S-000334-14, S-000397-14, and S-000594-14.

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:
Dignity, Choice and Privacy
Dining Observation
Medication
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 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 failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Staff #215 and the ADOC confirmed to the inspector resident #004's privacy interventions.

Staff #204, staff #214, and staff #215 confirmed to the inspector that direct care staff get care direction from the care plan. Staff #214 confirmed to the inspector that there was no privacy intervention information in the care plan for resident #004.

The inspector reviewed the care plan of resident #004 which does not include any focus of privacy for the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Staff #215 and the ADOC confirmed to the inspector resident #005's privacy interventions.

Staff #204, staff #214, and staff #215 confirmed to the inspector that direct care staff get care direction from the care plan. Staff #214 confirmed to the inspector that there was no privacy intervention information in the care plan for resident #005.

The inspector reviewed the care plan of resident #005 which does not include any focus of privacy for the resident. [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 to ensure that there is a written plan of care specific to privacy for residents #004 and #005 that sets out clear direction to staff and others who provide care to the residents, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

At approximately 0930, on December 30 2014 Inspector #580 observed that the home's servery, which opens to the residents' bedroom hallway, was unattended and contained pans of hot water used for keeping food hot and that several residents were walking in the hallway, and had unrestricted access to the servery and pans of hot water. Staff #203 confirmed to the inspector that the pans of water are hot and could burn a resident, and that usually the cook is present and the door is locked. [s. 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record is kept of the staffing plan evaluation, including the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented.

The Administrator/DOC and the ADOC confirmed to the inspector that the home does not have a written record of the annual staffing plan review. Inspector #580 reviewed the home’s Staff Allocation policy CA-02-19 dated August 2014 which includes an annual staffing evaluation, but the inspector did not find any written evaluation or summary of any changes made to the staffing plan. [s. 31. (4)]

Issued on this 24th day of February, 2015

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

Original report signed by the inspector.