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

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

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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
Oct 7, 2016	2016_391603_0015	019288-16	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

SYLVIE LAVICTOIRE (603)

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): July 19, 2016.

This complaint inspection is related to improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Residents, and Family Members.

The Inspector also directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs.

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

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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. 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had his or her right to participate in decision-making fully respected and promoted.

Inspector #603 reviewed a complaint submitted to the Director, from resident #001's family member. The complaint alleged improper care to resident #001, related to medication administration, and other care related issues.

Inspector #603 interviewed resident #001's family member who explained that on a certain date, resident #001 had been forcefully and without consent given a treatment. Resident #001's family member stated that staff had told them that at the time, resident #001 was swearing, yelling, incredibly upset and crying uncontrollably. The resident's family member further stated that on the next day, they met with PSW #104 and #105 to discuss the incident and advised them that resident #001 had the right to refuse any treatment.

Inspector #603 reviewed resident #001's progress notes and on that day, a treatment was given for a tympanic temperature of 38.1 degrees Celcius.

Inspector #603 interviewed RN #101 who explained that resident #001 was not capable of making all decisions for themself.

Inspector #603 interviewed the Administrator who explained that the home had educated staff not to force any resident with care. The Administrator also explained that in any case where a resident was "mentally incompetent", required a certain treatment and refused, the staff would notify the family. In this case, Inspector #603 reviewed the progress notes which failed to document that the staff had notified the family before the resident was given the treatment. [s. 3. (1) 9.]

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 ensuring that every resident has the right to have his or her participation in decision-making respected, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Inspector #603 reviewed a complaint submitted to the Director, from resident #001's family member. The complaint alleged improper care to resident #001, related to medication administration, and other care related issues.

Inspector #603 reviewed resident #001's progress notes which indicated that on a certain date, resident #001 was seen by a medical specialist and was prescribed a medication for 2 weeks. Eight days later, resident #001's family member asked staff if resident #001 was receiving this specific medication. The resident's family member explained that the family had left the prescription with the nurse in charge, the evening of the appointment. According to the progress note, the attending nurse confirmed that the resident had not been receiving the medication since the prescribed date, and would make sure they received the medication.

Inspector #603 interviewed RN #101 who explained that when medical specialists order medication, the staff are to contact the attending physician and approve the medication. RN #101 explained that in this case, there was a miscommunication between the home, the attending physician, and the pharmacy, and the resident never started the specific medication until nine days after it was prescribed. [s. 6. (4) (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 ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of are are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with and a response made to the person who made the complaint, indicating what the licensee had done to resolve the complaint.

Inspector #603 reviewed a complaint submitted to the Director, from resident #001's family member. The complaint alleged improper care to resident #001, related to medication administration, and other care related issues.

Inspector #603 interviewed resident #001’s family member who explained that they had brought forward many complaints to the Administrator, with no responses. The resident's

family member explained that on a certain date, they met with the Administrator to discuss their complaints about the resident #001's inability to eat properly based on a specific chair's position. Resident #001's family member said that the resident's chair had been removed and replaced by another one with no support, and that the resident had injured a body part from their specific chair. The resident's family member was told by the Administrator that they would follow up and ensure that something was done about their concerns however, they did not. Resident #001's family member also explained that on another occasion, they called the Administrator to complain about staff who were not using the resident's specific chair appropriately. The resident's family member stated that at that time, the Administrator was impatient and hung up the phone. At that point, resident #001's family member "reached the conclusion that it was pointless to discuss anything with the Administrator" and started calling the registered nurses with any of their concerns.

Inspector #603 reviewed the home's complaint logs which revealed no meeting or complaints submitted on that particular date, or about the specific chair.

Inspector #603 interviewed the Administrator who confirmed that the resident's specific chair had been removed on a certain date. The Administrator also explained that they did not remember a complaint filed by resident #001's family member regarding resident #001's specific chair and stated that many times, they had conversations with resident #001's family member and did not perceive these as complaints, therefore were never filed as such.

Inspector #603 reviewed the home's policy titled "Complaints Procedures #CA-02-14-1", dated May, 2010. The procedure revealed that "all verbal and written complaints are to be documented on the complaint log and if the verbal or written complaint alleges harm or risk of harm, the Administrator shall commence an investigation immediately and resolve, where possible, and a response will be provided to the complainant within 10 business days. If the complaint cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint including date of expected resolution must be provided to the complainant within 10 business days". [s. 101. (1) 3. i.]

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 ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with and a response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, to be implemented voluntarily.

Issued on this 26th day of October, 2016

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

Original report signed by the inspector.