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

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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2017	2017_633577_0008	007159-17	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

DEBBIE WARPULA (577)

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): April 19 and 20, 2017.

The following intake was inspected: one log related to a complaint concerning resident neglect, weight changes and a resident fall.

This Complaint inspection was conducted concurrently with a Critical Incident System inspection #2017_633577_0010 and a Follow up inspection #2017_633577_0009.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas and various common areas, observed provision of care and services to residents, observed staff to resident interactions, reviewed health care records for several residents and various policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Food Services Manager (FSM), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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. 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 has failed to ensure that residents were not neglected by the licensee or staff.

A complaint was received by the Director in 2017, related to resident #008's weight loss and nutritional status. The complaint report further indicated that the resident was transferred to another facility with a change in their medical condition.

Under O. Reg. 79/10, s. 5. neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Inspector #577 conducted a review of resident #008's electronic health record which revealed that the resident was transferred to another facility a short while after being admitted to the home.

Inspector #577 conducted a record review of resident #008's weight history and found that the resident had a 10.1 per cent weight loss over a 24 day period.

A record review of resident #008's current care plan with a nursing focus related to eating, indicated interventions for food preferences and supplements.

A review of the Registered Dietitian's (RD) initial assessment, indicated that resident #008's hydration risk level was assessed as high, had experienced severe weight loss and had a poor appetite and poor intake. The resident was to receive supplements.

Inspector #577 conducted a review of resident #008's 'Daily Food and Fluid Monitoring Sheet' for a specific month, and found the following:
-on six consecutive days-oral intake was < 1000 ml daily
-on eight consecutive days- oral intake was < 1000 ml daily
-on another eight consecutive days- oral intake was < 1000 ml daily; and

Refused meals:
-50% in the specific month, refused breakfast
-68% in the specific month, refused lunch
-75% in the specific month, refused dinner
-refused all meals a subsequent month.

Additionally, the following was found for the specific month:
-43% where resident was documented as taking only sips for their am nourishment;

-82% where the resident was documented as refusing their lunch fluids;
-39% where the resident was documented as refusing their fluids at dinner;
-53% where resident was documented as refusing their evening nourishment.

A review of the home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that significant weight changes were described as: 5 per cent or more in one month, 7.5 % or more in three months, 10% or more in six months, and any other weight change that compromises the resident's weight status. If the change in weight was confirmed as significant, staff were to complete a referral to the Registered Dietitian.

A review of the home's policy titled, "Hydration Management - CD-05-12-1", last revised date June 2010, indicated that residents with a fluid intake of less than 1000 ml for five consecutive days were referred to the Registered Dietitian. The policy further indicated the following:
-additional interventions were initiated for residents at risk for, or showing signs and symptoms of dehydration
-ongoing failure to meet an individual residents fluid requirements must be documented in the care plan and consideration given to alternate treatments: interventions such as IV therapy, hypodermacylsis, or enteral feeding to deal with long term consequences of ongoing inadequate fluid intake must be consistent with the residents Advance Directives.

A review of a nutritional note documented by the RD dated a month prior to the specific month, indicated that the resident had refused to eat over the past week, was taking sips of liquids only and the resident did not appear to understand their nutritional status. The progress note further indicated an order for a supplement and they would continue to follow and monitor the resident.

Inspector #577 reviewed resident #008's Advance Directive titled "Heath Care Treatment Plan" dated the month prior to the specific month. The advance directive indicated specific resident wishes, including those related to a decline in health associated to their nutritional status.

During an interview with RPN #100 on April 20, 2017, they reported to the inspector that resident #008's oral intake was fair and staff would give the resident a supplement to drink. They further reported that a resident would be referred to a RD on admission, and did not know any other circumstances when a resident would be re-referred to a RD.

During an interview with PSW #101, PSW #102 and PSW #103 on April 20, 2017, they reported that the resident would drink their supplement three times a day and would not eat their lunch.

During an interview with the Registered Dietitian on April 20, 2017, they reported that resident #008 had always had weight concerns, refused meals and the standard fluid requirement for resident #008 was 2000 milliliters (ml) per day. They further reported that a referral was sent a month prior to the specific month, where they had assessed the resident and further, staff should have requested another referral. They further reported that they did not assess the resident after their first assessment a month prior to the specific month, nor was a referral sent and aside from the supplements which were ordered, no other interventions or alternate treatments were considered.

During an interview with the Administrator/Director Of Care (ADM/DOC) on May 1, 2017, they reported that when a resident was assessed as a high nutritional risk for food and fluids, the Registered Dietitian was expected to conduct weekly assessments to track intake, make supplement recommendations and texture modifications, communicate with the physician and suggest further interventions if required.

During an interview with the Administrator/Director Of Care (ADM/DOC) on May 5, 2017, they reported that the Personal Support Worker's (PSW) were responsible to weigh residents every month, document it in the weight book, and when re-weighing the residents on the next consecutive month, they would check and compare the weight from the previous month. They further reported that when there was a significant difference, they were required to re-weigh the resident. When there was a significant difference with the weight, the PSW would report this to the registered staff and they would send a referral to the RD. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were reassessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated after a significant change in weight.

A complaint was received by the Director in 2017, related to resident #008's weight loss and nutritional status. The complaint report further indicated that the resident was transferred to another facility with a change in their medical condition.

Inspector #577 conducted a review of resident #008's electronic health record on April 20, 2017, which revealed that the resident was transferred to another facility a short while after being admitted to the home.

Inspector #577 reviewed resident #008's electronic weight record, which identified that over a 24 day period, there was a documented 10.1 per cent weight loss.

On April 20, 2017, Inspector #577 reviewed the progress notes for resident #008 for a three month period and no documentation was found identifying that a referral to the RD was made for the identified significant weight change, or that the RD was aware and an assessment had been completed to address the weight change.

A review of the home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSW's on the first bath day of the month, and registered staff were to record the weight into the electronic software

within the first ten days of the month. Resident's with a significant weight change would be re-weighed and the re-weigh recorded. Significant weight change were described as: 5 per cent or more in one month, 7.5 % or more in three months, 10% or more in six months, and any other weight change that compromises the resident's weight status. If the change in weight was confirmed as significant, staff were to complete a referral to the Registered Dietitian.

During an interview with RPN #100 on April 20, 2017, they reported that a resident would be referred to a RD on admission, and did not know any other circumstances when a resident would be re-referred to a RD.

During an interview with the RD, they reported that a referral was sent during a month, where they had assessed the resident. They further identified that a RD referral had not been received from the Registered Nursing staff for the significant weight change recorded in a specific month, or anytime thereafter for this resident, and should have, in accordance with the home's policy. They further confirmed that they had not assessed the resident after their first assessment which was one month prior to the resident's significant change in weight.

During an Administrator/Director Of Care (ADM/DOC) on May 5, 2017, they reported that the PSW's were responsible to weigh residents every month, document it in the weight book, and when re-weighing the residents on the next consecutive month, they would check and compare the weight from the previous month. They further reported that when there was a significant difference, they were required to re-weigh the resident. When there was a significant difference with the weight, the PSW would report this to the registered staff and they would send a referral to the RD. [s. 69. 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Issued on this 1st day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2017_633577_0008
Log No. / Registre no:	007159-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 12, 2017
Licensee / Titulaire de permis :	675412 ONTARIO INC 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	NORTHVIEW NURSING HOME 77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Gemmill

To 675412 ONTARIO INC, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A complaint was received by the Director in 2017, related to resident #008's weight loss and nutritional status. The complaint report further indicated that the resident was transferred to another facility with a change in their medical condition.

Under O. Reg. 79/10, s. 5. neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

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modifications, communicate with the physician and suggest further interventions if required.

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LTCHA, 2007 S.O. 2007, s. 19.(1) was previously issued as WN during Inspection #2014_336580_0025.

The decision to issue this compliance order was based on the severity which indicates actual risk and although the scope was isolated, there is a compliance history previously issued in this area of the legislation. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 26, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a resident with weight changes identified in O.Reg 79/10, s. 69 are assessed using an interdisciplinary approach, and that the actions are taken and outcomes are evaluated.
The plan shall include (but not limited to):

a) Educate all staff who provide direct care to the residents on the home's written policy "Weighing Residents". Once completed, the home must ensure that this policy is complied with. The home will maintain a record of training, what the training entailed, who completed the training and when the training was completed.

b) Ensure that the PSW's are communicating weight changes to the registered staff.

c) Ensure that the registered staff are completing referrals to the Registered Dietitian when there is a significant weight change.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were reassessed using an

interdisciplinary approach, and that actions were taken and outcomes evaluated after a significant change in weight.

A complaint was received by the Director in 2017, related to resident #008's weight loss and nutritional status. The complaint report further indicated that the resident was transferred to another facility with a change in their medical condition.

Inspector #577 conducted a review of resident #008's electronic health record on April 20, 2017, which revealed that the resident was transferred to another facility a short while after being admitted to the home.

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On April 20, 2017, Inspector #577 reviewed the progress notes for resident #008 for a three month period and no documentation was found identifying that a referral to the RD was made for the identified significant weight change, or that the RD was aware and an assessment had been completed to address the weight change.

A review of the home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSW's on the first bath day of the month, and registered staff were to record the weight into the electronic software within the first ten days of the month. Resident's with a significant weight change would be re-weighed and the re-weigh recorded. Significant weight change were described as: 5 per cent or more in one month, 7.5 % or more in three months, 10% or more in six months, and any other weight change that compromises the resident's weight status. If the change in weight was confirmed as significant, staff were to complete a referral to the Registered Dietitian.

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During an interview with the RD, they reported that a referral was sent during a month, where they had assessed the resident. They further identified that a RD

referral had not been received from the Registered Nursing staff for the significant weight change recorded in a specific month, or anytime thereafter for this resident, and should have, in accordance with the home's policy. They further confirmed that they had not assessed the resident after their first assessment which was one month prior to the resident's significant change in weight.

During an Administrator/Director Of Care (ADM/DOC) on May 5, 2017, they reported that the PSW's were responsible to weigh residents every month, document it in the weight book, and when re-weighing the residents on the next consecutive month, they would check and compare the weight from the previous month. They further reported that when there was a significant difference, they were required to re-weigh the resident. When there was a significant difference with the weight, the PSW would report this to the registered staff and they would send a referral to the RD. [s. 69. 4.]

LTCHA, 2007 S.O. 2007, r. 69 was issued previously as VPC during Inspection #2016_391603_0019, WN during Inspection #2015_380593_0018, VPC during Inspection #2014_140158_0005.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm/risk and the compliance history which despite a WN and two VPC's, NC continues with this are of the legislation. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

Service Area Office /
Bureau régional de services : Sudbury Service Area Office