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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2017	2017_633577_0009	032346-16, 032348-16, 032350-16, 032354-16, 032355-16	Follow up

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), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 19 and 20, 2017

The following intakes were inspected:

-one log related to Compliance Order #001, Inspection #2016_391603_0019 (A1), regarding plan of care;

-one log related to Compliance Order #002, Inspection #2016_391603_0019 (A1), regarding plan of care;

-one log related to Compliance Order #003, Inspection #2016_391603_0019 (A1), regarding restraints;

-one log related to Compliance Order #004, Inspection #2016_391603_0019 (A1), regarding complying with home's policies;

-one log related to Compliance Order #004, Inspection #2016_391603_0019 (A1), regarding restraints.

This Follow up inspection was conducted concurrently with a Critical Incident System inspection #2017_633577_0010 and a Complaint inspection #2017_633577_0008.

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 Nurses (RN), Registered Practical Nurses (RPNs), the representative of Motion Specialties, Personal Support Workers (PSWs) and Residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Nutrition and Hydration
Pain

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

- **4 WN(s)**
- **1 VPC(s)**
- **5 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to the staff and others who provided direct care to the residents.

Compliance Order (CO) #001 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to:
a) Ensure that all staff who provide direct care to residents have convenient and immediate access to the care plan.
b) Review and revise all resident care plans and kardexes to ensure that they set out clear directions to all front line staff and others who provide direct care to residents.
c) Educate and re-train all nursing staff regarding the importance of updating and communicating clear directions to staff and others who provide direct care to residents in order to ensure the resident's health, safety, and well being.
d) Develop and implement an auditing process which will identify care plans that do not set out clear directions so that corrections can be made.

While the home completed a, b, and d of the order, Inspector #577 determined that all nursing staff were not educated and re-trained on updating and communicating clear directions to staff and others who provide direct care to residents.

During a staff interview with PSW #101, PSW #102 and PSW #103 on April 20, 2017, they reported not having received training on care plans or reviewing care plans.

During a staff interview with RPN #107 on April 20, 2017, they reported a discussion

about updating care plans in a staff meeting a few months ago.

Inspector #577 interviewed the Administrator on April 20, 2017, and they reported that training was done in November 2016, but could not provide evidence that education and re-training was provided to staff. They further reported that the Personal Support Worker's (PSWs) were trained on reviewing the care plans and the registered staff were trained on the care plan policy, and how and when the care plans were to be updated. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Compliance Order (CO) #002 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to develop and implement a process to ensure that all residents who require a Personal Assistive Service Device (PASD) or a restraint received a comprehensive and formal assessment that included the resident's needs and preferences.

On April 19, 2017, Inspector #625 reviewed the PASD Physician Order sheet which indicated that resident #003 used an assistive device while in their wheelchair.

On April 20, 2017, Inspector #625 reviewed resident #003's current care plan that identified the resident used an assistive device for one of the two identified activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #003's "Safety Assessment- fall, restraint & bed rail - V 4" dated January 18, 2017, that indicated that the resident used an assistive device during two activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #003's PASD use was completed as indicated on the assessment titled "Safety Assessment- fall, restraint & bed rail - V 4" dated January 18, 2017. [s. 6. (2)]

3. On April 19, 2017, Inspector #625 reviewed the PASD Physician Order sheet which indicated that resident #005 used an assistive device for three activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #005's current care plan, that

identified the use of assistive devices for three activities of daily living as documented on the Physician Order sheet.

On April 20, 2017, Inspector #625 reviewed resident #005's "Restraint Assessment (New/Change, D/C order)" which did not reference the resident's use of an assistive device for one of the three identified activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #005's PASD use was completed as indicated on the assessment titled "Restraint Assessment (New/Change, D/C order)". [s. 6. (2)]

4. On April 19, 2017, Inspector #625 reviewed resident #009's Digital Prescriber's Orders which indicated that resident #009 used an assistive device for three activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #009's current care plan that identified the resident used an assistive device for the three activities of daily living as documented on the Digital Prescriber's Orders.

On April 20, 2017, Inspector #625 reviewed resident #009's "Safety Assessment - fall, restraint & bed rail - V4" dated January 17, 2017, which did not reference the resident's use of an assistive device for one of the three identified activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #009's assistive device and PASD use was completed as indicated on the assessment titled "Safety Assessment - fall, restraint & bed rail - V4" dated January 17, 2017. [s. 6. (2)]

5. On April 19, 2017, Inspector #625 reviewed resident #010's Digital Prescriber's Orders which indicated that the resident used an assistive device for two activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #010's current care plan that identified an assistive device in bath chair and an assistive device for the two activities of daily living as identified on the Digital Prescriber's Orders.

On April 20, 2017, Inspector #625 reviewed resident #010's "Restraint/PASD Assessment- 3 day trial (D/C)" dated March 2017. Day one was blank; day two indicated

an assistive device required for one of the two identified activities of daily living; and day three identified that the assistive device was still required. The assessment was not comprehensive and did not include an assessment of the resident's needs and preferences.

During an interview with Inspector #625 on April 20, 2017, RN #104 stated that they were not aware of any restraint assessments on Point Click Care and if a new assistive device was initiated in the home, the RN was not able to identify that they would be required to complete an assessment related to the device use.

During an interview on April 20, 2017 with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #010's PASD and restraint use was limited to what was indicated on the assessment titled "Restraint/PASD Assessment-3 day trial (D/C)" completed March 20, 2017. When the Inspector asked about the various restraint and/or PASD assessments completed for the assessment of residents #003, #005, #009 and #010, the Coordinator stated that some staff may have completed different assessments from each other for the restraint/PASD use, or completed the incorrect assessment, had supplemented the assessment with a progress note if the assessment wasn't fully or correctly completed, or had possibly completed a hard copy of an assessment instead of an electronic assessment.

During interviews on April 20, 2017, the Administrator stated that residents in the home used an assistive device for a certain activity of daily living as per the home's policy, that the assistive device was referred to as a PASD by the home and that all components related to the use of assistive device for this particular activity of daily living may not have been completed. With respect to the use of the "Restraint/PASD Assessment-3 day trial (D/C)", the Administrator stated that the specific assessment was to be completed when the home trialed discontinuing an assistive device. The Administrator was unable to locate any other assessment of resident #010's assistive device in the resident's chart. The Administrator acknowledged that there was no specific restraint/PASD assessment identified and communicated to the registered staff to complete.

The home failed to complete a comprehensive and formal assessment that included residents #003, #005, #009, #010 needs and preference related use of an assistive device for a particular activity of daily living, which the home had identified in the resident's plan of care as a PASD; and the use of an assistive device when being used to support a resident with a different activity of daily living as the home had identified as a restraint. The home had also failed to develop and implement a consistent

comprehensive and formal assessment for residents who required a PASD or a restraint that included the resident's needs and preferences. [s. 6. (2)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The home failed to ensure that all residents with a physical restraint had an order given by the physician or the registered nurse in the extended class.

Compliance Order (CO) #003 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to ensure that all residents with a physical restraint have an order given by the physician or a registered nurse in the extended class.

On April 19, 2017, Inspector #625 reviewed resident #009's health care record including:
- a "Digital Physician's Orders" sheet dated December 2016, that ordered a restraint;
- a "Physician Medication Review" sheet dated January 2017, that read "Discontinue all previous orders". Under the "restraints" section the document read "N/A" and the review did not include the resident's use of a restraint; and
- the current care plan that identified the resident used a restraint.

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that they were not able to locate a physician's order in resident #009's chart, which included the most recent "Physician Medication Review" sheet dated January 2017.

During an interview on April 19, 2017, the Administrator acknowledged that the physician's order dated December 2016, for a restraint, was not listed on the "Physician Medication Review" sheet dated January 2017. The Administrator acknowledged that resident #009 did not have a current physician's order for the restraint as the December 2016, order had been discontinued when the "Physician Medication Review" had been completed on January 25, 2017. [s. 31. (2) 4.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Compliance Order (CO) #004 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to review and re-educate all staff and others who provided direct care to the residents on the home's written "Restraints", "Weighing Residents", and "Documentation – HCA/PSW Resident Care Flow Sheet" policies. Once completed, the home would ensure that those policies were complied with.

During a staff interview with PSW #101, PSW #102, and PSW #103 on April 20, 2017, they reported to Inspector #577 that they had not received training on the home's policies specific to "Weighing Residents", and "Documentation – HCA/PSW Resident Care Flow Sheet".

Inspector #577 interviewed the Administrator on April 20, 2017, and they reported that training was not done on the policy for "Weighing Residents". They further reported that training on "Documentation – HCA/PSW Resident Care Flow Sheet" was completed in November 2016, but could not provide evidence that re-education was provided to the staff. [s. 8. (1) (a),s. 8. (1) (b)]

2. A Critical Incident System (CIS) report was received by the Director in 2017, related to resident #007's fall which resulted in a significant change in condition.

Inspector #577 conducted a record review of resident #007's progress notes dated for a specific month, which indicated the following:

-at a specific time in the evening-resident was found on the floor in pain and assisted to bed
-later the resident was in greater pain related to specific actions and stated they hurt in a specific area, medication was given for pain, and staff would continue to monitor.

A record review of resident #007's post-fall assessment completed after their fall, revealed that the resident was experiencing pain.

On April 20, 2017, the Inspector reviewed the home's most current policy titled "Fall prevention and Management program - CN-F-05-1" lasted revised March 2017, which indicated that when a resident falls they were assessed by registered staff and depending on the circumstances of the fall and the injuries, this may include the following information documented in point click care:
-vitals and neuro-vitals
-head-to-toe assessment
-Range of Motion (ROM) assessment
-skin/wound care
-pain level

A further record review of resident #007's progress notes related to the fall, did not reveal a completed head-to-toe assessment or ROM assessment.

Inspector #577 conducted an interview on April 20, 2017, with RPN #107 who reported that when a resident falls, they would conduct a head to toe assessment, assess vital signs and the RN would document a fall progress note.

During an interview with the Administrator on April 20, 2017, they confirmed that a progress note should have been documented after the fall, which should have included an assessment of the resident.

During an interview with the Administrator on May 12, 2017, they confirmed that it was expected as part of the home's procedure that for any unwitnessed falls, staff were required to perform vital signs, neurovital signs, a head to toe assessment, ROM assessment, skin/wound care, and a pain level assessment. [s. 8. (1) (a),s. 8. (1) (b)]

3. A complaint was received by the Director in 2017, related to a CIS report, concerning resident #007's pain level (related to a fall) that was not properly treated as well as the length of time it took to send the resident to another facility for an assessment.

Inspector #577 conducted a record review of resident #007's progress notes, which indicated the following:
-at a specific time the resident was found on the floor complaining of pain to a specific area, was assisted back to bed
-the resident was in greater pain related to specific actions, resident stated they hurt, medication was given for pain, and staff would would continue to monitor.

A record review of resident #007's post-fall assessment completed revealed that the resident was experiencing pain.

On April 20, 2017, the Inspector reviewed the home's policy titled "Pain management policy -CN-P-09-1" last revised January 2016, which indicated the following:
-each resident should be assessed for pain on admission, re-admission, quarterly and with a change in condition that impacts pain or causes new pain.
-if a resident has indicators of pain then an assessment was done; for cognitive residents, the cognitive pain assessment was done in point click care.
-the health care team had a responsibility to identify pain as an issue that required management and treatment.
-if a resident had indicators of pain then an assessment would be done.
-residents who experienced pain would be considered for non-pharmacological and/or pharmacological interventions.
-reassess resident upon admission, quarterly or a change in condition that impacts pain or causes new pain or if resident indicated ongoing unrelieved pain.

During a record review of resident #007's chart for pain assessments, Inspector #577 did not locate a completed electronic pain assessment. The Inspector reviewed the electronic health record with the RAI Coordinator who confirmed that a pain assessment was not completed.

A record review of resident #007's Medication Administration Records (MARS) dated two specific days, revealed that the resident received pain medication for complaints of pain, post fall on a specific day.

Inspector #577 conducted an interview on April 20, 2017, with the Administrator who reported that a pain assessment was required to be done with any new pain and should have been done for resident #007 after their fall when they were complaining of pain. They further reported that the resident only had pain at specific times, and if the resident

was immediately transferred to another facility, they would not have received specific assessments until the morning. [s. 8. (1) (a),s. 8. (1) (b)]

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

a) 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 less than a specific amount
-on eight consecutive days-oral intake was less than a specific amount
-on another eight consecutive days-oral intake was less than a specific amount

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 milliliters (ml) for five consecutive days were to be referred to the Registered Dietitian.

During an interview with RPN #107 on April 20, 2017, they reported to Inspector #577 that a resident would be referred to an RD on admission, and stated they were not sure when else they would refer a resident.

During an interview with Registered Dietitian #106 on April 20, 2017, they confirmed that they did not assess the resident after their first assessment a month prior to the specific month, nor was a referral sent.

b) Inspector #577 conducted a review of resident #008's 'Daily Food and Fluid Monitoring Sheet' for a specific month, and found that resident had 22/28 days where their oral fluid intake was less than a specific amount.

A review of the home's policy titled, "Hydration Management - CD-05-12-1", last revised date June 2010, 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.

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.

A review of the Registered Dietitian's initial assessment indicated that resident's hydration risk level was assessed as a specific level and they required additional nutritional treatment.

During an interview with Registered Dietitian #106 on April 20, 2017, they reported that resident #008 had specific nutritional/hydration requirements that were not met and other than the above treatment, no other interventions or alternate treatments were considered.

During an interview with the Administrator on May 1, 2017, they reported that when a resident was assessed as a specific 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.

c) Inspector #577 reviewed resident #008's 'Daily Food and Fluid Monitoring" record for a specific month, and found the following missing entries:
-two days missing for am nourishment
-four days missing for pm nourishment
-10 days missing for dinner fluids

A review of the home's policy titled, "Documentation – HCA/PSW Resident Care Flow Sheet CN-D-19-1" with no date, indicated that PSW's must document intake of food and fluid for all meals and snacks on the Nutritional Flow Chart on each shift.

During an interview with the Administrator on April 19, 2017, they reported to Inspector #577 that PSW's were responsible for recording the intake of food and fluid for all meals and snacks on the flowsheet and the registered staff tally the results. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirement was met where a resident was being restrained by a physical device under section 31 of the Act: that the staff applied the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

On April 19, 2017, Inspector #625 observed resident #010 seated in a wheelchair with a specific assistive device in place. The assistive device was applied incorrectly.

During an interview on April 19, 2017, with Inspector #625, PSW #108 acknowledged that the assistive device was incorrectly applied to resident #010.

During an interview with Inspector #625 on April 19, 2017, a representative of Motion Specialties #109 observed resident #010 in the wheelchair and stated that parts of the device were installed incorrectly.

Inspector #625 then interviewed the Administrator who viewed resident #010 seated in the wheelchair with the assistive device, and acknowledged that the assistive device was not positioned properly. The Administrator also acknowledged that the physician had ordered an assistive device which did not include additional parts of the device that were applied. The Administrator further acknowledged that the improper application of the assistive device posed a safety hazard to resident #010.

On April 20, 2017, during an interview with Inspector #625, the Administrator stated that the resident had been seated in the incorrect wheelchair, that they should not have had the specific assistive device that had been applied as a different assistive device, and that they did not know how the resident had used the incorrect wheelchair with the wrong assistive device on.

On April 19 and 20, 2017, Inspector #625 reviewed resident #010's current care plan that indicated the resident used a specific assistive device and a "Digital Prescriber's Orders" sheet dated March 20, 2017 that contained a physician' order the same. The physician's order did not reflect the assistive device that was used for resident #010 in their wheelchair. [s. 110. (2) 2.]

2. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Compliance Order (CO) #005 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Inspector #625 reviewed resident #009's current care plan which indicated that the resident used a restraint.

On April 19, 2017, Inspector #625 reviewed resident #009's "Restraint +/or PASD /c Restraining Flow Sheet" for the month of April 2017. The flow sheet identified that a specific device was used as a restraint and contained an area titled "Registered Staff Reassessment (Every 8 Hours and prn)". There were no registered staff initials for 18 out of 19 night shifts (or 95 per cent of the night shifts), for three out of 18 day shifts (or 17 per cent of the day shifts), and for one out of 18 evening shifts (or 6 per cent of the evening shifts).

The home's policy "Restraints - CN-R-05" last revised February 2016, identified that registered staff were to document the reassessment and effectiveness of assistive devices, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. This documentation would be recorded on the "Restraint +/or PASD /c Restraining Flow Sheet".

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that registered nursing staff were required to initial resident #009's "Restraint +/or PASD /c Restraining Flow Sheet", under the column titled "Registered Staff Reassessment (Every 8 Hours and prn)" to indicate that the resident's use of the assistive device was reassessed, including evaluation of the effectiveness of the assistive device. The RN stated that the registered staff should have initialed for each eight hour period, including the night shift, but acknowledged that this had not been completed every eight hours.

During an interview on April 19, 2017, the Administrator acknowledged that resident #009's "Restraint +/or PASD /c Restraining Flow Sheet" had not been initialed every eight hours as required, on multiple evening and night shifts. The Administrator stated that registered staff may have thought that they were to sign only when the assistive device was in use, but that they should be signing every eight hours to indicate that reassessment of the resident's condition and evaluation of the effectiveness had occurred. [s. 110. (2) 6.]

3. Inspector #625 reviewed resident #010's current care plan which indicated that the resident used a specific restraint.

On April 19, 2017, Inspector #625 reviewed resident #010's "Restraint +/or PASD /c Restraining Flow Sheet" for the month of April 2017. The flow sheet identified that a specific device was used as a restraint and contained an area titled "Registered Staff Reassessment (Every 8 Hours and prn)". There were no registered staff initials for 11

out of 19 night shifts (or 58 per cent of the night shifts), for two out of 18 day shifts (or 11 per cent of the day shifts), and for one out of 18 evening shifts (or 6 per cent of the evening shifts).

The home's policy "Restraints - CN-R-05" last revised February 2016, identified that registered staff were to document the reassessment and effectiveness of restraints on the "Restraint +/or PASD /c Restraining Flow Sheet, at least every eight hours, and at any time when necessary based on the resident's condition or circumstances".

A review of the 'Restraint and/or PASD with Restraining Flow Sheet' indicated that PSW's were responsible for monitoring and initialing every hour and registered staff were responsible for reassessment and initialing every eight hours.

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that registered nursing staff were required to initial resident #009's "Restraint +/or PASD /c Restraining Flow Sheet", under the column titled "Registered Staff Reassessment (Every 8 Hours and prn)" to indicate that the resident's use of the assistive device was reassessed, including evaluation of the effectiveness of the assistive device. The RN stated that the registered staff should have initialed for each eight hour period, including the night shift, but acknowledged that this had not been completed every eight hours.

During an interview with Inspector #625 on April 20, 2017, RN #104 stated that they had worked night shifts in the home and were familiar with the "Restraint +/or PASD /c Restraining Flow Sheet" and, as a registered nurse, they would not sign for the restraints ordered over eight hours of the night shift if the restraints were not in use during those hours.

During an interview on April 19, 2017, the Administrator acknowledged that resident #010's "Restraint +/or PASD /c Restraining Flow Sheet" had not been initialed every eight hours as required, on multiple shifts. The Administrator stated that registered staff may have thought that they were to sign only when the assistive device was in use, but that they should be signing every eight hours to indicate that reassessment of the resident's condition and evaluation of the effectiveness had occurred. [s. 110. (2) 6.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the following requirement is met where a resident is being restrained by a physical device under section 31 of the Act: that the staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class, to be implemented voluntarily.

Issued on this 7th 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), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2017_633577_0009
Log No. / Registre no:	032346-16, 032348-16, 032350-16, 032354-16, 032355-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 15, 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:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0019, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:

Educate and re-train all nursing staff regarding the importance of updating and communicating clear directions to staff and others who provide direct care to residents in order to ensure the resident's health, safety, and well-being. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to the staff and others who provided direct care to the residents.

Compliance Order (CO) #001 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to:
a) Ensure that all staff who provide direct care to residents have convenient and immediate access to the care plan.
b) Review and revise all resident care plans and kardexes to ensure that they set out clear directions to all front line staff and others who provide direct care to residents.
c) Educate and re-train all nursing staff regarding the importance of updating and communicating clear directions to staff and others who provide direct care to

residents in order to ensure the resident's health, safety, and well being.
d) Develop and implement an auditing process which will identify care plans that do not set out clear directions so that corrections can be made.

While the home completed a, b, and d of the order, Inspector #577 determined that all nursing staff were not educated and re-trained on updating and communicating clear directions to staff and others who provide direct care to residents.

During a staff interview with PSW #101, PSW #102 and PSW #103 on April 20, 2017, they reported not having received training on care plans or reviewing care plans.

During a staff interview with RPN #107 on April 20, 2017, they reported a discussion about updating care plans in a staff meeting a few months ago.

Inspector #577 interviewed the Administrator on April 20, 2017, and they reported that training was done in November 2016, but could not provide evidence that education and re-training was provided to staff. They further reported that the Personal Support Worker's (PSWs) were trained on reviewing the care plans and the registered staff were trained on the care plan policy, and how and when the care plans were to be updated. [s. 6. (1) (c)]

Non-compliance was previously identified under Inspection #2016_391603_0019, including a compliance order served December 6, 2016, Voluntary Plan of Correction (VPC) during Inspection #2015_380593_0018, VPC during Inspection #2014_336580_0026, VPC during Inspection #2014_140158_0005, and VPC during Inspection #2013_140158_0038.

The decision to re-issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite one previous compliance order, 4 previous VPCs, NC continues with this area of the legislation. (577)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0019, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall:

a) Develop and implement a process to ensure that all residents who require a Personal Assistance Service Device (PASD) or a restraint receive a comprehensive and formal assessment that includes the residents' needs and preferences.

b) The Director of Care or designate will audit the PASD or restraint assessments.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Compliance Order (CO) #002 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to develop and implement a process to ensure that all residents who require a Personal Assistive Service Device (PASD) or a restraint received a comprehensive and formal assessment that included the resident's needs and preferences.

On April 19, 2017, Inspector #625 reviewed the PASD Physician Order sheet which indicated that resident #003 used an assistive device while in their wheelchair.

On April 20, 2017, Inspector #625 reviewed resident #003's current care plan that identified the resident used an assistive device for one of the two identified activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #003's "Safety Assessment- fall, restraint & bed rail - V 4" dated January 18, 2017, that indicated that the resident used an assistive device during two activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #003's PASD use was completed as indicated on the assessment titled "Safety Assessment- fall, restraint & bed rail - V 4" dated January 18, 2017. [s. 6. (2)]
(625)

2. On April 19, 2017, Inspector #625 reviewed resident #009's Digital Prescriber's Orders which indicated that resident #009 used an assistive device for three activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #009's current care plan that identified the resident used an assistive device for the three activities of daily living as documented on the Digital Prescriber's Orders.

On April 20, 2017, Inspector #625 reviewed resident #009's "Safety Assessment - fall, restraint & bed rail - V4" dated January 17, 2017, which did not reference the resident's use of an assistive device for one of the three identified activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #009's assistive device and PASD use was completed as indicated on the assessment titled "Safety Assessment - fall, restraint & bed rail - V4" dated January 17, 2017. [s. 6. (2)]
(625)

3. On April 19, 2017, Inspector #625 reviewed the PASD Physician Order sheet which indicated that resident #005 used an assistive device for three activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #005's current care plan, that identified the use of assistive devices for three activities of daily living as documented on the Physician Order sheet.

On April 20, 2017, Inspector #625 reviewed resident #005's "Restraint Assessment (New/Change, D/C order)" which did not reference the resident's use of an assistive device for one of the three identified activities of daily living.

During an interview on April 20, 2017, with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #005's PASD use was completed as indicated on the assessment titled "Restraint Assessment (New/Change, D/C order)". [s. 6. (2)] (625)

4. On April 19, 2017, Inspector #625 reviewed resident #010's Digital Prescriber's Orders which indicated that the resident used an assistive device for two activities of daily living.

On April 20, 2017, Inspector #625 reviewed resident #010's current care plan that identified an assistive device in bath chair and an assistive device for the two activities of daily living as identified on the Digital Prescriber's Orders.

On April 20, 2017, Inspector #625 reviewed resident #010's "Restraint/PASD Assessment- 3 day trial (D/C)" dated March 2017. Day one was blank; day two indicated an assistive device required for one of the two identified activities of daily living; and day three identified that the assistive device was still required. The assessment was not comprehensive and did not include an assessment of the resident's needs and preferences.

During an interview with Inspector #625 on April 20, 2017, RN #104 stated that they were not aware of any restraint assessments on Point Click Care and if a new assistive device was initiated in the home, the RN was not able to identify that they would be required to complete an assessment related to the device use.

During an interview on April 20, 2017 with Inspector #625, RAI Coordinator #100 confirmed the home's assessment of resident #010's PASD and restraint use was limited to what was indicated on the assessment titled "Restraint/PASD Assessment-3 day trial (D/C)" completed March 20, 2017. When the Inspector asked about the various restraint and/or PASD assessments completed for the

assessment of residents #003, #005, #009 and #010, the Coordinator stated that some staff may have completed different assessments from each other for the restraint/PASD use, or completed the incorrect assessment, had supplemented the assessment with a progress note if the assessment wasn't fully or correctly completed, or had possibly completed a hard copy of an assessment instead of an electronic assessment.

During interviews on April 20, 2017, the Administrator stated that residents in the home used an assistive device for a certain activity of daily living as per the home's policy, that the assistive device was referred to as a PASD by the home and that all components related to the use of assistive device for this particular activity of daily living may not have been completed. With respect to the use of the "Restraint/PASD Assessment-3 day trial (D/C)", the Administrator stated that the specific assessment was to be completed when the home trialed discontinuing an assistive device. The Administrator was unable to locate any other assessment of resident #010's assistive device in the resident's chart. The Administrator acknowledged that there was no specific restraint/PASD assessment identified and communicated to the registered staff to complete.

The home failed to complete a comprehensive and formal assessment that included residents #003, #005, #009, #010 needs and preference related use of an assistive device for a particular activity of daily living, which the home had identified in the resident's plan of care as a PASD; and the use of an assistive device when being used to support a resident with a different activity of daily living as the home had identified as a restraint. The home had also failed to develop and implement a consistent comprehensive and formal assessment for residents who required a PASD or a restraint that included the resident's needs and preferences. [s. 6. (2)]

Non-compliance was previously identified under Inspection #2016_391603_0019, including a compliance order served December 6, 2016.

The decision to re-issue this compliance order was based on the scope which was widespread, the severity which indicated potential for actual harm and the compliance history which despite one previous compliance order, NC continues with this area of the legislation. (625)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0019, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that all residents with a physical restraint, specifically resident #009, have an order given by the physician or the registered nurse in the extended class.

Grounds / Motifs :

1. The home failed to ensure that all residents with a physical restraint had an order given by the physician or the registered nurse in the extended class.

Compliance Order (CO) #003 was issued during Inspection

#2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to ensure that all residents with a physical restraint have an order given by the physician or a registered nurse in the extended class.

On April 19, 2017, Inspector #625 reviewed resident #009's health care record including:
- a "Digital Physician's Orders" sheet dated December 2016, that ordered a restraint;
- a "Physician Medication Review" sheet dated January 2017, that read "Discontinue all previous orders". Under the "restraints" section the document read "N/A" and the review did not include the resident's use of a restraint; and
- the current care plan that identified the resident used a restraint.

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that they were not able to locate a physician's order in resident #009's chart, which included the most recent "Physician Medication Review" sheet dated January 2017.

During an interview on April 19, 2017, the Administrator acknowledged that the physician's order dated December 2016, for a restraint, was not listed on the "Physician Medication Review" sheet dated January 2017. The Administrator acknowledged that resident #009 did not have a current physician's order for the restraint as the December 2016, order had been discontinued when the "Physician Medication Review" had been completed on January 25, 2017. [s. 31. (2) 4.]

Non-compliance was previously identified under Inspection #2016_391603_0019, including a compliance order served December 6, 2016, and WN during Inspection #2015_380593_0018.

The decision to re-issue this compliance order was based on the scope which was a pattern, the severity which indicated potential for actual harm and the compliance history which despite one previous compliance order, NC continues with this area of the legislation. (625)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0019, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall:

Review and re-educate all staff and others who provide direct care to the residents on the home's policies, as follows:
a) "Fall prevention and Management"
b) "Hydration Management"
c) "Pain Management"
d) "Documentation - HCA/PSW Resident Care Flow Sheet"
The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Compliance Order (CO) #004 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to review and re-educate all staff and others who provided direct care to the residents on the home's written "Restraints", "Weighing Residents", and "Documentation – HCA/PSW Resident Care Flow Sheet" policies. Once completed, the home would ensure that those policies were

complied with.

During a staff interview with PSW #101, PSW #102, and PSW #103 on April 20, 2017, they reported to Inspector #577 that they had not received training on the home's policies specific to "Weighing Residents", and "Documentation – HCA/PSW Resident Care Flow Sheet".

Inspector #577 interviewed the Administrator on April 20, 2017, and they reported that training was not done on the policy for "Weighing Residents". They further reported that training on "Documentation – HCA/PSW Resident Care Flow Sheet" was completed in November 2016, but could not provide evidence that re-education was provided to the staff. [s. 8. (1) (a),s. 8. (1) (b)] (577)

2. A complaint was received by the Director in 2017, related to a CIS report, concerning resident #007's pain level (related to a fall) that was not properly treated as well as the length of time it took to send the resident to another facility for an assessment.

Inspector #577 conducted a record review of resident #007's progress notes, which indicated the following:
-at a specific time the resident was found on the floor complaining of pain to a specific area, was assisted back to bed
-the resident was in greater pain related to specific actions, resident stated they hurt, medication was given for pain, and staff would would continue to monitor.

A record review of resident #007's post-fall assessment completed revealed that the resident was experiencing pain.

On April 20, 2017, the Inspector reviewed the home's policy titled "Pain management policy -CN-P-09-1" last revised January 2016, which indicated the following:
-each resident should be assessed for pain on admission, re-admission, quarterly and with a change in condition that impacts pain or causes new pain.
-if a resident has indicators of pain then an assessment was done; for cognitive residents, the cognitive pain assessment was done in point click care.
-the health care team had a responsibility to identify pain as an issue that required management and treatment.
-if a resident had indicators of pain then an assessment would be done.
-residents who experienced pain would be considered for non-pharmacological

and/or pharmacological interventions.
-reassess resident upon admission, quarterly or a change in condition that impacts pain or causes new pain or if resident indicated ongoing unrelieved pain.

During a record review of resident #007's chart for pain assessments, Inspector #577 did not locate a completed electronic pain assessment. The Inspector reviewed the electronic health record with the RAI Coordinator who confirmed that a pain assessment was not completed.

A record review of resident #007's Medication Administration Records (MARS) dated two specific days, revealed that the resident received pain medication for complaints of pain, post fall on a specific day.

Inspector #577 conducted an interview on April 20, 2017, with the Administrator who reported that a pain assessment was required to be done with any new pain and should have been done for resident #007 after their fall when they were complaining of pain. They further reported that the resident only had pain at specific times, and if the resident was immediately transferred to another facility, they would not have received specific assessments until the morning. [s. 8. (1) (a),s. 8. (1) (b)]
(577)

3. A Critical Incident System (CIS) report was received by the Director in 2017, related to resident #007's fall which resulted in a significant change in condition.

Inspector #577 conducted a record review of resident #007's progress notes dated for a specific month, which indicated the following:
-at a specific time in the evening-resident was found on the floor in pain and assisted to bed
-later the resident was in greater pain related to specific actions and stated they hurt in a specific area, medication was given for pain, and staff would continue to monitor.

A record review of resident #007's post-fall assessment completed after their fall, revealed that the resident was experiencing pain.

On April 20, 2017, the Inspector reviewed the home's most current policy titled "Fall prevention and Management program - CN-F-05-1" lasted revised March

2017, which indicated that when a resident falls they were assessed by registered staff and depending on the circumstances of the fall and the injuries, this may include the following information documented in point click care:
-vitals and neuro-vitals
-head-to-toe assessment
-Range of Motion (ROM) assessment
-skin/wound care
-pain level

A further record review of resident #007's progress notes related to the fall, did not reveal a completed head-to-toe assessment or ROM assessment.

Inspector #577 conducted an interview on April 20, 2017, with RPN #107 who reported that when a resident falls, they would conduct a head to toe assessment, assess vital signs and the RN would document a fall progress note.

During an interview with the Administrator on April 20, 2017, they confirmed that a progress note should have been documented after the fall, which should have included an assessment of the resident.

During an interview with the Administrator on May 12, 2017, they confirmed that it was expected as part of the home's procedure that for any unwitnessed falls, staff were required to perform vital signs, neurovital signs, a head to toe assessment, ROM assessment, skin/wound care, and a pain level assessment. [s. 8. (1) (a),s. 8. (1) (b)]
(577)

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

a) 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 less than a specific amount
-on eight consecutive days-oral intake was less than a specific amount
-on another eight consecutive days-oral intake was less than a specific amount

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 milliliters (ml) for five consecutive days were to be referred to the Registered Dietitian.

During an interview with RPN #107 on April 20, 2017, they reported to Inspector #577 that a resident would be referred to an RD on admission, and stated they were not sure when else they would refer a resident.

During an interview with Registered Dietitian #106 on April 20, 2017, they confirmed that they did not assess the resident after their first assessment a month prior to the specific month, nor was a referral sent.

b) Inspector #577 conducted a review of resident #008's 'Daily Food and Fluid Monitoring Sheet' for a specific month, and found that resident had 22/28 days where their oral fluid intake was less than a specific amount.

A review of the home's policy titled, "Hydration Management - CD-05-12-1", last revised date June 2010, 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.

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.

A review of the Registered Dietitian's initial assessment indicated that resident's hydration risk level was assessed as a specific level and they required additional nutritional treatment.

During an interview with Registered Dietitian #106 on April 20, 2017, they reported that resident #008 had specific nutritional/hydration requirements that were not met and other than the above treatment, no other interventions or alternate treatments were considered.

During an interview with the Administrator on May 1, 2017, they reported that when a resident was assessed as a specific 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.

c) Inspector #577 reviewed resident #008's 'Daily Food and Fluid Monitoring" record for a specific month, and found the following missing entries:
-two days missing for am nourishment
-four days missing for pm nourishment
-10 days missing for dinner fluids

A review of the home's policy titled, "Documentation – HCA/PSW Resident Care Flow Sheet CN-D-19-1" with no date, indicated that PSW's must document intake of food and fluid for all meals and snacks on the Nutritional Flow Chart on each shift.

During an interview with the Administrator on April 19, 2017, they reported to Inspector #577 that PSW's were responsible for recording the intake of food and fluid for all meals and snacks on the flowsheet and the registered staff tally the results. [s. 8. (1) (b)]

Non-compliance was previously identified under Inspection #2016_391603_0019, including a compliance order served December 6, 2016, and WN during Inspection #2014_336580_0025.

The decision to re-issue this compliance order was based on the scope which was a pattern, the severity which indicated potential for actual harm and the compliance history which despite one previous compliance order, NC continues with this area of the legislation. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2017

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0019, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall:

a) Ensure that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

b) The Director of Care or designate will audit the Restraint Flow Sheets.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Compliance Order (CO) #005 was issued during Inspection #2016_391603_0019 with a compliance date of December 31, 2016. The licensee was ordered to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Inspector #625 reviewed resident #009's current care plan which indicated that the resident used a restraint.

On April 19, 2017, Inspector #625 reviewed resident #009's "Restraint +/or PASD /c Restraining Flow Sheet" for the month of April 2017. The flow sheet identified that a specific device was used as a restraint and contained an area titled "Registered Staff Reassessment (Every 8 Hours and prn)". There were no registered staff initials for 18 out of 19 night shifts (or 95 per cent of the night shifts), for three out of 18 day shifts (or 17 per cent of the day shifts), and for one out of 18 evening shifts (or 6 per cent of the evening shifts).

The home's policy "Restraints - CN-R-05" last revised February 2016, identified that registered staff were to document the reassessment and effectiveness of assistive devices, at least every eight hours, and at any other time when

necessary based on the resident's condition or circumstances. This documentation would be recorded on the "Restraint +/or PASD /c Restraining Flow Sheet".

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that registered nursing staff were required to initial resident #009's "Restraint +/or PASD /c Restraining Flow Sheet", under the column titled "Registered Staff Reassessment (Every 8 Hours and prn)" to indicate that the resident's use of the assistive device was reassessed, including evaluation of the effectiveness of the assistive device. The RN stated that the registered staff should have initialed for each eight hour period, including the night shift, but acknowledged that this had not been completed every eight hours.

During an interview on April 19, 2017, the Administrator acknowledged that resident #009's "Restraint +/or PASD /c Restraining Flow Sheet" had not been initialed every eight hours as required, on multiple evening and night shifts. The Administrator stated that registered staff may have thought that they were to sign only when the assistive device was in use, but that they should be signing every eight hours to indicate that reassessment of the resident's condition and evaluation of the effectiveness had occurred. [s. 110. (2) 6.] (625)

2. Inspector #625 reviewed resident #010's current care plan which indicated that the resident used a specific restraint.

On April 19, 2017, Inspector #625 reviewed resident #010's "Restraint +/or PASD /c Restraining Flow Sheet" for the month of April 2017. The flow sheet identified that a specific device was used as a restraint and contained an area titled "Registered Staff Reassessment (Every 8 Hours and prn)". There were no registered staff initials for 11 out of 19 night shifts (or 58 per cent of the night shifts), for two out of 18 day shifts (or 11 per cent of the day shifts), and for one out of 18 evening shifts (or 6 per cent of the evening shifts).

The home's policy "Restraints - CN-R-05" last revised February 2016, identified that registered staff were to document the reassessment and effectiveness of restraints on the "Restraint +/or PASD /c Restraining Flow Sheet, at least every eight hours, and at any time when necessary based on the resident's condition or circumstances".

A review of the 'Restraint and/or PASD with Restraining Flow Sheet' indicated

that PSW's were responsible for monitoring and initialing every hour and registered staff were responsible for reassessment and initialing every eight hours.

During an interview with Inspector #625 on April 19, 2017, RN #105 stated that registered nursing staff were required to initial resident #009's "Restraint +/or PASD /c Restraining Flow Sheet", under the column titled "Registered Staff Reassessment (Every 8 Hours and prn)" to indicate that the resident's use of the assistive device was reassessed, including evaluation of the effectiveness of the assistive device. The RN stated that the registered staff should have initialed for each eight hour period, including the night shift, but acknowledged that this had not been completed every eight hours.

During an interview with Inspector #625 on April 20, 2017, RN #104 stated that they had worked night shifts in the home and were familiar with the "Restraint +/or PASD /c Restraining Flow Sheet" and, as a registered nurse, they would not sign for the restraints ordered over eight hours of the night shift if the restraints were not in use during those hours.

During an interview on April 19, 2017, the Administrator acknowledged that resident #010's "Restraint +/or PASD /c Restraining Flow Sheet" had not been initialed every eight hours as required, on multiple shifts. The Administrator stated that registered staff may have thought that they were to sign only when the assistive device was in use, but that they should be signing every eight hours to indicate that reassessment of the resident's condition and evaluation of the effectiveness had occurred. [s. 110. (2) 6.]

Non-compliance was previously identified under Inspection #2016_391603_0019, including a compliance order served December 6, 2016.

The decision to re-issue this compliance order was based on the scope which was widespread, the severity which indicated potential for actual harm and the compliance history which despite one previous compliance order, NC continues with this area of the legislation. (625)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 15, 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 15th 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